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Understanding 'Poor Performing' General Practices Findings from Five Qualitative Case Studies

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**Understanding ‘Poor Performing’ General Practices:
A Qualitative Study of Five General Practices with
Low Quality and Outcomes Framework Scores**

Maria Kordowicz

Thesis submitted to King’s College London for the degree of
Doctor of Philosophy

January 2016

DEDICATION

I dedicate this thesis to my grandparents, Halina and Stanisław.

I hope I have made you proud.

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Thank you to my academic supervisors, Dr Mark Ashworth, Professor Ewan Ferlie and my former supervisor Professor Roger Jones. Your support and belief in me has seen me through. Your intelligence and insights have been inspiring. Mark, thank you for being a fantastic role model to me both professionally and personally. Your influence has been the true reward of the PhD process.

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ABSTRACT

Background

Defining poor GP performance through the target-driven lens of the Quality and Outcomes Framework (QOF) has its limitations. General practices which consistently underperform on QOF may be disengaged with top-down quality improvement initiatives – their characteristics remaining largely unknown.

Aim

Through an ethnographically informed social constructionist methodological approach, I set out to capture the qualitative characteristics of ‘poor performers’ which lie beyond QOF targets.

Method

I spent time embedding myself in the day-to-day reality of five practices across England, which have consistently scored in the lowest 10% of QOF scores nationally, since QOF’s inception. As a participant observer, I conducted interviews with the practices’ teams, kept field notes and sourced practice documents. The data were then analysed to identify key themes pertaining to the practices’ reactions to QOF and organised into case studies.

Findings

Contrary to what would be expected from ‘poor performers’, there was evidence of high quality service delivery in some of the participating practices. The overarching themes concerned professional values and responses to QOF surveillance. A typology of the participating practices is proposed.

Implications

This is the first time QOF poor performers and their responses to QOF have been studied in depth and by bringing together rich multi-source qualitative data. This thesis is important in recognising the values driving ‘poor performing’ general practices and the multi-faceted nature of quality patient care, and thus in highlighting the limitations of ‘one size fits all’ quality improvement initiatives. Government regulation is discussed in the context of surveillance and presented within a Foucauldian framework, supported further by current theory. It is suggested that in order to be effective, performance management must appeal more directly to the values driving general practitioners and their teams. The study contributes to knowledge by attempting to reframe current understandings of responses to surveillance and by presenting a typology of persistently low QOF scoring general practices.

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*‘The Panopticon is a marvellous machine which,
whatever use one may wish to put it to,
produces homogeneous effects of power.’*

Michel Foucault (1975)

1. INTRODUCTION

Within the policy backdrop of New Public Management, which saw a shift away from traditional public administration towards the application of private sector principles to public management, the general practice Quality and Outcomes Framework (QOF) was, at the time of the study, the largest healthcare pay-for-performance scheme in England, with the aim of performance management and quality improvement through evidence-based target indicators. This thesis presents an ethnographically-informed qualitative study of five persistently low QOF scoring general practices across England. The findings are presented as five case studies, with a sixth case study as a synthesis of overarching themes. The research is a comment on the limitations of pay-for-performance schemes as an indicator of quality of care. The significance of values in how the low QOF scorers perceive QOF is explored. Furthermore, the study proposes a new theoretical framework to conceptualise responses to surveillance and suggests a typology of low QOF scoring practices. The study will now be introduced with a summary of the background to the research, the research questions with which it is concerned, along with a brief outline of the thesis chapters.

1.1 Background to the Research

A cohort of general practices, which consistently failed to achieve scores outside of the lowest ten per cent of QOF scores nationally, was identified. It was considered to be of research interest to gain a greater understanding of these practices, in order to discover whether indeed QOF helped to capture ‘poor’ performance and to draw conclusions about why these practices continued to underperform. It was assumed that this would have implications for the effectiveness of future quality improvement initiatives and would also potentially highlight some of the shortcomings of top-down financially incentivised performance improvement schemes in universally driving quality within general practice. The research was also conducted to enhance not only the academic, but also the professional learning of the researcher, whose professional background in healthcare management consultancy often placed her in service contexts which were deemed to be underperforming, with the often challenging task of ‘turning them around’. It was hoped, therefore, that the understandings gleaned from the research process would also inform and improve the professional practice of the author.

The author entered the research process with an awareness of the existence of a growing political push for ever greater improvement and transparency in healthcare delivery; the resulting burden of increased bureaucracy and remote data monitoring potentially causing a rift between top-down managerial mandates and professionals ‘on the ground’. It was felt that an ethnographically-informed study would help to elucidate the perceptions and dynamics within general practice in ways that indicator-driven computerised quality improvement schemes, such as QOF, could not.

1.2 Research Questions

The study was based around the following research objective and broad inductive research questions:

The primary research objective –

To gain an understanding of general practices which achieved low Quality and Outcomes Framework scores over a five-year period.

The secondary research questions -

- How is QOF perceived by the practice staff?
- How do the participating low scoring general practices respond to a top-down target-driven quality improvement initiative?
- What role does professionalism play in how the practices respond to regulation?
- Why do some general practices continue to underperform on the Quality and Outcomes Framework?
- What do the participating low scoring general practices do in terms of quality of care, beyond the scope of the Quality and Outcomes Framework?

1.3 Chapter Overview

The initial chapters of the thesis are inductive and explore the socio-political and public policy backdrop, as presented in the literature, to the regulation of the healthcare sector. These background chapters outline the introduction of QOF within general practice and describe the quality improvement framework. The chapter “Performance Management in Healthcare” explores some of the challenges with the assumptions of such frameworks and their implementation. The policy backdrop to performance management in the NHS is discussed, followed by an analysis of New Public Management. Through a literature review, concepts of quality are explored and the problematic nature of defining quality in healthcare is highlighted. Successive chapters discuss some of the challenges of a ‘pay for performance’ scheme such as QOF and identify issues around supposed ‘poor performance’ being captured through QOF scores. Following on from this, a group of persistent ‘poor performers’ is identified. Then, two potential theoretical frameworks for furthering understanding of these practices are suggested. To end the background and literature review chapters, theoretically-informed research questions are posed.

The methods chapter follows. The structure of the thesis continues with a rationale for and a theoretically-driven explanation of the ethnographically informed qualitative research methodology and design. This is then followed by a step-by-step outline of the research process. Limitations of the research methodology are also discussed.

The proceeding chapter presents the findings as case studies for each general practice visited, followed by an overarching case study, drawing the findings together into overall themes and typologies. These findings are then analysed within the theoretical

discussion. Building on prior theory around government regulation and professionalism, a new theoretical framework for understanding the responses of healthcare practitioners to top down surveillance is proposed. Practical applications for practice and policy are explored. Limitations of the study are highlighted and suggestions for further research made. Finally, the concluding remarks draw together the contributions of this study. There are a number of appendices added to the thesis, which include supportive material and published work to date.

2. BACKGROUND

Along with a review of policy, this chapter will introduce key concepts surrounding performance management within general practice and some of the controversies it poses. Performance management and healthcare quality are two very broad topics. The background section in some ways only scratches the surface; however, it sets the scene for development of existing theory, in light of the findings generated by the thesis.

Theory plays a significant role in qualitative research. It influences several elements of research (Kelly, 2010), notably:

- The development of research questions
- The research design and methodology
- Data analysis
- New theory building.

To give the reader a greater insight into the research process, it is worth noting even at this stage, that the writing of the thesis has been iterative, with the background section tailored post data analysis to highlight some of the key concepts relevant to the findings of the study. This also allows for the thesis to be more succinct and to give greater validity to the presentation of the findings. As such, a number of potential theoretical frameworks, initially explored in the literature review, were rejected at a later stage of the study. These were complexity theory, which had limited application, along with Mintzberg's professionalised bureaucracy which was deemed over-simplistic and usurped by studies of professionalism in light of increasing surveillance.

2.1 Performance Management in Healthcare

This section of the background chapter introduces and explores some of the constructs and understandings which abound the concept of performance management within healthcare, particularly through the use of incentive schemes.

In order to understand performance management, one must first define performance itself. Numerous attempts have been made at defining performance. Most simply, performance refers to the way someone or something functions, whilst in management terms, it is the achievement of a given task against pre-set standards. The discipline of performance management applies a number of tools and technologies in order to motivate teams and services to perform better by meeting established standards.

Within health services, a number of standard frameworks have been proposed for capturing and improving performance. General practice performance may be assessed on areas such as effectiveness, equity and efficiency (Kruk & Freedman, 2008), safety and patient outcomes (Gillam & Siriwardena, 2011) or access and effectiveness (Campbell et al., 2000), to name but three.

A King's Fund report (2011), highlighted that in the current climate of NHS reforms the goal of improving 'NHS performance and hence the quality of patient care' remains a priority. This statement highlights a tendency in the academic and policy literature to use the words 'performance' and 'quality' almost interchangeably, indicating that high quality care is the product of good performance and that a quality health service is also a high performing one. To take this further, this suggests that performance measures and standard frameworks in healthcare have an overarching aim of achieving high quality care.

Whilst still in its infancy relative to the business professions, performance measurement is seen to be an important tool for improving care quality and increasing the accountability of healthcare organisations (Adair et al., 2006). Performance measurement refers to the process of gathering and analysing performance data of an individual, group or organisation. It may also involve evaluating interventions used to improve performance. As the NHS has become more complex, it now routinely applies business tools to measure and evaluate performance. A significant facilitator of the application of performance indicators in healthcare, and perhaps the root of some of the problems associated with performance management through their use, has been the ubiquitous drive for evidence-based medicine, which will be briefly reviewed here.

Historically, medical practice has been viewed as the application of professional knowledge, taken from physiological understandings and clinical experience (Djulbegovic et al., 2000). This perspective was contested by Cochrane (1972), arguing that the practice of medicine lacked robust evidence to support its effectiveness. This claim formed the beginnings of a push for greater standardisation and evidence-based practice (Miles et al., 2000), with evidence sourced from statistical data, namely meta-analyses and randomised controlled trials being viewed as superior to other forms. Yet, the evidence-based medical model was defined by Sackett (1997) as the application of not only the best available clinical evidence from systematic research to the care of individual patients, but also of individual clinical expertise. It is likely that with the introduction of ever-greater performance management through standardisation within healthcare, the clinical expertise element of evidence-based medicine has been somewhat neglected. Sackett did warn of this influx of current best external population-

based evidence as putting medical practice at risk of becoming 'tyrannised' by interventions that may not be suitable for the individual patient.

Nonetheless, there are a number of strengths to the evidence-based medicine model. It enables the systematic identification, appraisal and application of up-to-date research findings as the basis for clinical decisions. The almost universal computerisation of general practice and the development of so called 'inpractice' systems that permit the rapid location of relevant evidence, have made it easier for busy clinicians to make best use of the published research in order to inform their clinical decisions. Therefore, it could be argued that, evidence-based medicine has actively narrowed the gulf between clinical research and clinical practice. Doctors are now better informed with contemporaneous new findings and can make informed diagnostic and treatment decisions more quickly and with greater ease, supported by information technologies (Rosenberg & Donald, 1995).

However, this has been contested by Gabbay & Le May (2004) whose ethnographic study suggested that clinicians rarely use explicit systematic research evidence to make clinical decisions. Rather, clinicians use what the authors coined 'mindlines' – collectively reinforced, tacit guidelines based on experience. Through the ethnographic study of just two general practices, this work was able to elicit data which were sufficiently rich in highlighting the influence of informal interactions on patient care and clinical decision making. The authors of this paper nonetheless promoted the use of best available evidence in guiding the 'mindlines' themselves, but in order to be utilised effectively, the evidence-base required informal dissemination through networks, rather than formal models. This current thinking puts a question mark over

the historical roots of the evidence-based approach, which stemmed from the promotion of standardisation to improve efficiency.

The drive for evidence-based medicine can be viewed as rooted in scientific management or Taylorism (named after Frederick W. Taylor, its founding father). Taylorism's main objectives were to improve productivity and economic efficiency, through scientifically-based methods. Traditionally, methods such as supervision and clear setting of standards, along with standardisation of the work process, had their first application in mass production factories. Taylor's aim of achieving task optimisation remains a key principle in industry today and underpins the management tool of establishing systems of rewards for meeting pre-set goals.

Incentive frameworks, therefore, build on the original principles of scientific management. However, one of Taylor's four principles of the approach was to obtain 'intimate friendly cooperation between the management and the workers' (Taylor, 1914). Therefore, it could be argued that a lack of engagement from workers, here the low QOF scoring general practitioners, could undermine the effectiveness of Taylorist methodology i.e. QOF. It would be of interest to explore how disengagement with the tool affects its organisational influence. And yet, defining general practitioners as 'workers' may be over-simplistic, as general practitioners are for the most part self-employed contractors.

Thus, general practitioners are independent contractors accountable to, but not directly employed by, the state health service. One of the advantages of the contractor model, is that it gives general practitioners the freedom to act as patient advocates, retaining also an accountability to the communities they serve. Thus, it could be argued that the contractor model allows GPs to remain somewhat independent of management,

allowing general practice to remain a clinically-led service. Yet, this notion of independence and autonomy has been rejected by some, particularly in the public media, which tends to present GPs as being at the mercy of the demands of the NHS system. Indeed, at the time of field work, GP performance and contract compliance, along with QOF output, was closely monitored and managed by the Primary Care Trusts (PCTs). The monitoring, inspection and regulation of general practice has since been taken up by the Care Quality Commission (CQC).

Opinions are divided over the strengths and limitations of this self-employed partner model, in existence since the inception of the National Health Service. As an aside, it should be noted that the contractor status itself has been criticised as an attempt of the state to reduce the costs of direct employment, creating unrealistic financial and administrative pressures for the individual GP. GPs are expected to fund their own training, professional memberships and insurance without state financial support.

Nonetheless, GPs' contractor status poses a question mark over the potential for them to ever be truly directly managed as an independent professional group. Furthermore, this raises questions of the malleability of professional groups in general, with their own set of professional codes of conduct, guidance and memberships to guide them, to the demands of top down state management. Thus, there may be an ill fit between evidence-based, scientific management methodologies and general practice as its subject.

Whilst Taylorism has no doubt been of huge influence in shaping modern thinking about how optimal performance in workers is achieved, its one-size-fits-all approach, in particular the lack of applicability to a wide range of organisational settings (Taylorist ideas stem from improving industrial efficiency), has oft been criticised.

Noble (1984), in his seminal book “Forces of Production”, identified these shortcomings. He stated ‘no absolute science of metal cutting could be developed – there were simply too many stubborn variables to contend with.’ Here, scientific management was applied to machining. Healthcare, with its numerous complexities, interacting variables and stakeholder demands, is undoubtedly an even more complex entity, where this approach is unlikely to flourish.

Thus, the historical lessons in the wider applicability of Taylor’s model appear to have been somewhat ignored with the introduction of reward-based systems in order to improve the performance of clinicians. A further layer of supervision has been added to this framework in modern times, with the advent of information technologies. Evidence-based medicine, has brought about a culture of electronic patient data collection within healthcare, especially general practice. These data lend themselves easily to performance monitoring and measurement and can be compared against benchmarks and standards. To take this a step further, a key tool in performance management is the use of indicators as benchmarks of good performance, and clinical consultation data can be judged against those indicators, to allow (former) PCT managers in the case of general practice to draw conclusions about clinical performance.

The drive for standardisation of work delivery in healthcare has been linked to a number of concepts. In turn, these concepts are also viewed as facets of quality. These are safety, effectiveness, patient-centeredness, timeliness, efficiency and equity (Timmermans & Berg, 2003). A drive to understand the quality of care which a GP practice provides would therefore comprise of these facets, with patient-centeredness arguably being more difficult to measure than the others. It is also possible of course,

that a practice may provide quality care in some areas and not others. The GP may offer timely appointments, but not provide the patient with respect for their values or an integrated experience, as patient-centred care demands.

It is the limitations of the evidence-based approach, however, that are of particular relevance to this study. These shortcomings may help to shed light on the apparent disengagement of low scorers from QOF – consistently low scorers, statistical outliers, being of central interest to this study. The participants of the study will be introduced in more detail in the Methods chapter.

Evidence-based practice underpins the use of indicators to improve performance. QOF indicators are developed by a committee of the National Institute for Health and Clinical Excellence and formulated on the basis of best available current evidence concerning financially incentivised quantifiable and standardisable aspects of care in general practice. However, it is for this reason that QOF is vulnerable to the same criticisms which apply to evidence-based medicine and it being used to inform performance management through standardisation in healthcare, namely that it provides a limited view of GP quality.

Further criticisms of increased standardisation relate to discourses of tension between medical professionals and management (this construct will be explored in more detail within Chapter 3). The key here is the threat evidence-based medicine poses to a doctor's professional autonomy. Doctors are now faced with standardised frameworks and templates to order their consultations and diagnostic processes. Whilst these tools can be useful as time-saving devices for the diagnosis and treatment of the majority of their patient population, they may remove scope for intuition and professional decision-making (e.g. Kramer, 2012). Paradigm shifts in medical thinking were often the result

of individual cases that didn't fit the mould (e.g. Phineas Gage in the field of neuroscience), and thus evidence-based medicine may prevent a doctor from treating outliers with the unique approach required.

Indeed, there are parallels here with the very premise of this thesis, which is concerned with phenomena that do not fit the expected mould. Evidence-based medicine, through undermining the recognition of the unique person/case, may hamper innovation and threaten person-centredness. However, it has been suggested that the evidence-based approach and the professional value of person-centeredness can be reconciled. A paper by Sanders, Harrison and Checkland (2010), exploring heart failure nurses' interactions with protocol-driven care, concluded that the nurses were able to implement evidence-based protocols into their daily routine, whilst still preserving a personalised approach to care. Yet, the authors do note that even within this approach, protocol-driven care did encroach on space within the consultation to explore patients' own priorities, and call for an incorporation of the patient's own values into the consultation process.

Moreover, the evidence touted as gold standard within evidence-based medicine, may have a number of shortcomings (e.g. Feinstein & Horwitz, 1997). The lab-based simulated conditions under which randomised controlled trials are carried out for instance, commonly with a sample of young, healthy, males, do not translate well to real-life care settings. The danger here is the production of inappropriate and unsafe guidelines for clinical practice as a result of this research.

A further criticism of evidence-based practice, upon which performance management in healthcare is often based, stems from the advent of technologies introduced into clinical practice in order to 'supervise' its implementation as mentioned previously. Data-based outputs from a consultation are now routinely entered onto a computer

software programme during the general practice consultation. Various ‘inpractice’ programmes automatically compute these data, based on pre-set algorithms, and respond with prompts for the consultation. A number of these prompts are directly linked to the requirements of QOF and other quality improvement initiatives.

Utilising ethnographic research methods, it has been argued that certain technologies used within general practice promote a power asymmetry between the professional and the patient. This is due to the clinician holding an element of control over the patient record, which the patient doesn’t possess (Swinglehurst, 2014). From a humanist perspective, the introduction of this ‘third-player’ in the consultation in the form of computer technology (Kumarapeli & De Lusignan, 2013), has reduced patients to objects and undermined patient-centred care and professional autonomy. It can be concluded that performance management models stemming from evidence-based medicine are likely to produce tensions between experiential and patient-centred clinical knowledge and population-based, technological approaches favoured by them. These clashes, and in particular professionalism versus surveillance through standardisation, will feature highly throughout the thesis.

With time, these technologies came to not just serve the purpose of achieving increased standardisation within the clinical process, but also to act as a tool in public performance management by the state. Within QOF, data entered onto the system by general practitioners were now evaluated against certain pre-set standards. Rationalised by the Behaviourist incentive theory of motivation, meeting of those standards would be rewarded with a financial bonus, in order to motivate the clinician to maintain their performance. A lack of achievement against standards brought about penalties (e.g. non-payment) and an intervention from the former PCTs. Thus, technologies became

a tool of monitoring and regulating performance through practice data surveillance. The impact of surveillance technologies will be appraised within Chapter 3.

Furthermore, in their review of the role of incentives in the public sector, Burgess and Ratto (2003) maintain that optimal incentive structures in the public sector may differ from those in the private sector. They outline four reasons why the applicability of incentive schemes to the public sector is highly problematic, namely multiple principals and lines of accountability, extreme measurement problems, intrinsic motivation, and the importance of teams in generating outputs and outcomes. To apply this to general practice, general practitioners are clearly accountable to and seek guidance from multiple principals, including regulatory bodies, patients and professional membership organisations, such as the Royal College of General Practitioners. From the perspective of Burgess and Ratto, extreme measurement problems refer to the inadequacy of performance management frameworks in capturing complex data regarding the multiple goals and outputs of public sector organisations. Indeed, general practice has been likened to a complex, self-evolving system (Kordowicz, 2012), which suggests that the problems Burgess and Ratto raise are even more acutely applicable to the field of general practice.

Similarly, Burgess and Ratto discuss that the motivation of public sector workers is largely intrinsic, and external motivators such as financial rewards are far less relevant than in the private sector. In line with oft-cited psychological studies of motivation (e.g. Deci, Koestner & Ryan, 1999; Ryan & Deci, 2000), it may be that increasing external incentives may undermine the more intrinsic altruistic motivations, such as helping patients, upholding values of professionalism and the like. These studies of motivation stem from research within education settings which suggested that verbal reward

(appealing to intrinsic motivations) was more effective than tangible extrinsic rewards such as gold stars, which tended to undermine internal drivers of good performance.

The importance of a successful team infrastructure is highly applicable to running a general practice, with multiple roles and tasks at both clinical and administrative levels needing to be fulfilled in order to support patient pathways and care. However, QOF financial rewards are paid out directly to the GP Principal, thus not directly rewarding members of the teams that also contributed to QOF achievement which, though a tangible reward, may undermine the motivations of the wider staff team to continue to sustain QOF performance.

In addition, it can be argued that quality improvement through reward for the use of numerical indicators is a paradox, as it does not capture ‘soft’ data. By ignoring the qualitative aspects of care, such as compassion and the doctor patient relationship, it strays from a meaningful capture of the phenomenon of quality. Therefore, QOF as a monitor of and incentive for good performance has its limitations. Thus, one could argue that the framework is reductionist, and creates perverse incentives whereby QOF performance is all it captures, rather than performance in terms of overall service quality. However, QOF has resulted in some meaningful changes in primary care. These are reviewed later within this chapter in the section entitled “Quality and Outcomes Framework”.

Yet, the managerialist culture of quality improvement extends to constantly refining quality improvement initiatives, thereby attempting to challenge this paradox. This is evidenced by the National Institute for Health and Clinical Excellence, which is tasked with the development of QOF indicators, producing a revised ‘menu’ of indicators

yearly, which takes into account previous QOF performance, the potential emergence of a new evidence base and the development of new care guidelines.

Healthcare performance measurement itself is largely seen to be rooted in the work of Avedis Donabedian (e.g. 1966, 1997), the ‘father of quality assurance’ (Best & Neuhauser, 2004), who argued for a model for assessing healthcare which was based on an understanding of three interconnected factors: structure, process and outcome. Outcome is defined in terms of ‘recovery, restoration, and of survival’ of the patient. Process is concerned with whether ‘good medical care has been applied’ – which itself takes into consideration several factors, such as ‘technical competence in the performance of diagnostic and therapeutic procedures,’ and ‘coordination and continuity of care.’ Structure pertains to the ‘administrative and related processes that support and direct the provision of care.’ In most basic terms, one can view the outcome as the completion of a patient’s treatment, the process as the means by which the outcome is achieved, and the structure can be understood the broader framework within which it took place. It is because of Donabedian’s influence that performance monitoring in health tends to be concerned with information representing all three domains (Frenk, 2000).

However, performance measurement in healthcare remains a controversial topic, namely because healthcare is a complex entity and does not lend itself easily to measurement. Suggesting that quality assurance in health is merely a tool in a hugely multifaceted environment, Donabedian himself is cited as saying:

‘As I have repeatedly said: structure-process-outcome is a servant, not a master. I never intended to build my reputation on this paradigm. I only offered it as a handy classification scheme. I know that it has deeper meaning.....’

Avedis Donabedian, last remarks, March 2000 cited in Harteloh (2003)

Therefore, the controversy of performance measurement is the result of the difficulty of defining quality of care, and whether what is being captured through performance measurement tools is in fact meaningful.

As such, numerous attempts have been made at defining general practice quality. The problematic nature of defining quality for the purpose of performance management will be explored later in the section entitled “Concept of ‘Quality’ in Healthcare”. Nonetheless, the trend in government policy over time has been to classify NHS services on the basis of their performance against top-down standards, as high or low performers. Data of performance are widely available within the public domain, under the policy rhetoric of greater transparency and patient choice.

Talbot (2005) sees the growth of performance indicators from the 1980s onwards in public services management as resulting from New Public Management activity. In the UK, the approach was top down, implemented as part of administrative drives to improve performance. Targets were designed to capture more easily measurable outputs, rather than overall patient outcomes. As a critique of target frameworks, it could be argued that outputs are much more concerned with the process, rather than the outcome for the patient in terms of their wellbeing. Whilst indicators within QOF are evidence-based, it is not clear to what extent high scores on those indicators really achieve high quality care for the patient.

The level of achievement on performance indicators has since the 1980s been distilled into publicly visible league tables, whereby public services are labelled as either a ‘poor’ or a ‘successful’ performer. There were sanctions for the former result, with

enforced replacement of senior leadership figures for instance, and rewards for high scores, which included increased operational autonomy (Ferlie, 2016). No doubt publicly available performance league tables can either encourage or undermine the trust of users in that service. Therefore, it may be of interest to this study if the label of ‘poor’ performer has in any way been detrimental to the study’s participants.

Furthermore, performance indicators became closely aligned with the aims of economic efficiency under ‘New’ Labour. Services were monitored for the value for money they offered the tax payer. In the case of QOF, a focus on meeting evidence-based standards within primary care would reduce the costly burden placed on secondary care. To support this aim further, the achievement of points in areas of disease prevention, for example health promotion, and not just intervention, was incentivised.

Under ‘New’ Labour the use of performance targets across the health services continued to grow. Probably the most prominent of these concerned the reduction in Accident and Emergency (A&E) waiting times. The achievement of four hour wait targets, or otherwise, were widely publicised in the mass media. Overall, there appeared to be a significant reduction in waiting times under ‘New’ Labour, though it is likely that a proportion of these improvements were not down to real changes, rather gaming strategies undertaken by the NHS Trusts (Mears, 2014).

For instance, there were reports of A&E departments carrying out nurse-led triage within the four hour window so that the patient could be recorded as having been seen, whilst treatment may have been withheld for a significant amount of hours post this. Perverse effects such as patients waiting on temporary beds in hospital corridors, so that the ‘box’ of the patient having been given a bed could be ticked, were also reported

as being in operation. Gaming as applied to QOF will be reviewed later in the Background chapter.

Therefore, the star rating system for hospitals implemented by the Department of Health in 2001, did at times come under fire as to how reflective it was of true performance. Yet, under the drive for increased performance management in healthcare, more information was being made available to patients to enable them to make choices about where they wanted their treatment to take place. The reality, however, was that patients were still often bound by their postcodes as to the level of services that were available within their referring GP's Trust. Managerially, poorly performing hospitals could be singled out, as they often were within the press, and advisory bodies such as the NHS Modernisation Agency would put intense interventions into place to raise performance against top down standards. A lack of significant improvement within a prescribed timeframe could result in financial sanctions of closure.

As a reflection of this climate of gaming along with the imposition of top-down punitive measures, this period of performance management through targets was aptly coined 'Targets and Terror' by Bevan and Hood (2006). Next the policy context leading up to this era, within which QOF is firmly rooted, will be reviewed.

2.2 Policy Context of Performance Management in the NHS

This chapter will discuss the policy backdrop to performance monitoring in the NHS and how, over time, performance capture for the purpose of quality improvement has become ubiquitous within the public sector.

Since the foundation of the NHS in a post-war climate in 1948, government policy papers revealed financial tensions and power shifts between the clinical and managerial domains. As early as two years into its operations, a ceiling on NHS expenditure was imposed and successive reports highlighted the need for financial astuteness, such as the “Guillebaud” (1956) and “Porritt” (1962) reports. The financial pressures on the NHS have continued to mount over consecutive decades, with significant cuts in spending imposed under the previous Conservative/Liberal coalition of 2010 and embraced by the Conservative government of 2015 at the time of writing.

Significantly, Margaret Thatcher’s reforms played a key role in establishing performance management within the public sector. 1980-1990 brought an unrelenting focus on efficiency, resource control and accountability. Under Thatcher, the introduction of competitive tendering for ancillary NHS services demanded potential providers to be able to demonstrate a level of both financial and service performance which would secure contracts. Towards the end of Thatcher’s time in office, internal markets, along with a purchaser/provider split, were introduced into the NHS, working on the assumption that increased competition drives service performance.

Moving into John Major’s government (1990-1997), the “Patients Charter” (Department of Health, 1991) recognised the central role of patient choice in improving service quality. Policy discourse of the patient as a consumer was introduced, whereby

more options should be offered to the patient to enable them to ‘vote with their feet’. Considerations about best value to the tax payer were highlighted and it was proposed that the patient voice should be at the centre of service and policy decisions. In order for this to happen, patients had to be well-informed and there were calls for greater transparency about NHS service performance, through publicly available performance data e.g. hospital league tables. However, some of the limitations of measuring performance against top-down indicators as a marker of quality came to the fore in 1996, when league tables were criticised by professional bodies as pointless and misleading after ranking some of the country’s leading hospitals among the worst performers (Goldstein & Spiegelhalter).

Yet, under Tony Blair (1997-2007), ‘New’ Labour wholeheartedly embraced principles of driving quality improvement through performance management. The policy language of the time in the “Modernising Government” (1999) and “Our Healthier Nation” (1999) White Papers became increasingly influenced by private sector principles. The focus was on reviewing NHS services and identifying best suppliers for them. New targets and performance indicators were introduced to achieve ‘real improvements’ and ‘quality and effectiveness’. These goals were supported by a new information technology strategy and infrastructure, regular audits and data submission from those on the ground to management and, in turn, to the government bureaucrats.

It is worth noting, that this top-down target-driven audit-led era of governance is coined New Public Management (Ferlie, 1996), with its origins firmly rooted in Thatcherite principles of public sector management. The features and subsequent impact of New Public Management on the control of the public healthcare sector will be explored in more depth in the following section.

Under ‘New’ Labour targets were designed to be ‘tougher but attainable’ and there was a recognition of the need to focus on priority areas. Contracts were put into place between central government and local services, with local providers having to evidence the quality of their service delivery. There was particular drive for reducing health inequalities, with a clear focus on primary care for public health gains, in order to reduce the utilisation of more expensive secondary care. “The NHS Plan” (Department of Health, 2000) paved the way for standard setting with an annual assessment of NHS organisations, along with the publication of results in the public domain. It is within this climate that QOF was introduced in 2004.

Forming the policy backdrop to the times during which the fieldwork was undertaken, the loftily titled White Paper of the Conservative/Liberal Democrat Coalition “Equity and Excellence: Liberating the NHS” (2010) set out the plans for GP Commissioning, a reduction in management costs by more than 45% and £20 billion of efficiency savings. Alongside this, the new Health and Social Care Act (2012), focussed on greater transparency and accountability, with increased powers given to regulatory bodies, such as the Care Quality Commission (CQC) replacing PCTs, in order to monitor and inspect health and social care services and take enforcement action where necessary. It is clear that performance management through the use of quality indicators and monitoring is not going anywhere any time soon.

In parallel to these developments regarding the use of performance management in the NHS, prompted by economic considerations, the debates around clinical versus managerial leadership in the NHS also began around the time of the inception of the NHS. Initially, hospitals were clinically led by a matron and a medical superintendent. The “Porritt Report” (1962) proposed that doctors should hold the position of chief

officers of area boards. Four years later, the “Farquharson-Lang Report” (1966) stated that chief executives need not be medically qualified. The same year, the “Salmon Report” pushed for raising the profile of the (cheaper) nursing profession in hospital management. The 1970s saw the advent of multidisciplinary management teams and power devolved to local health authorities under the 1972 “NHS Reorganisation” White Paper. It is clear, that there were a number of concerns around the roles managers versus clinicians should play in the administration of the NHS, with managers potentially posing a threat to the clinicians’ expertise and the clinicians perhaps not being best utilised or best placed to manage financial resources and lead teams.

Famously under Margaret Thatcher’s rule, Sir Roy Griffiths (1983) was commissioned to write a report into the effectiveness of the public sector. This appointment was controversial, as Griffiths had been the former deputy chairperson of Sainsbury’s supermarkets, a for profit retail business, driven by private sector principles, which were seen to be at odds with the value-driven altruistic public sector ethos (Le Grand & Bartlett, 1993; Le Grand, 2003). Griffiths (1983), emphasising the need for improved management in the NHS, is famously cited as saying:

‘If Florence Nightingale were carrying her lamp through the NHS today, she would be searching for the people in charge.’

Thatcher’s era of New Public Management brought about increased non-clinical leadership of the NHS, with a power shift away from professionals to budget-holding managers and market incentives to improve efficiency. This continued under ‘New’ Labour, with numerous commentators lamenting the increased managerialisation of the healthcare sector and the bureaucratic mechanisms employed as methods of control (e.g. McAvoy & Kaner, 1996; Smith, 2001). Today, the recent shift to Conservative

rule in the UK, has reversed the trend of non-clinical management. The present government's drive to implement clinical leadership is evidenced by GP commissioning, for instance, along with their commitment to reduce management costs by almost half.

However, it is important to consider some of the policy and social dynamics leading up to and during QOF's inception, within the context of New Public Management. The next section of the thesis will explore the features of New Public Management in more detail and revisit the use of incentives in NHS performance management against its backdrop.

2.3 New Public Management

This section will give a brief overview of some of the features of New Public Management, and suggest that the implementation of QOF across general practice is a product of this era.

New Public Management is the term which refers to an era of public management based on Thatcherite principles of the introduction of market incentives into the public sector in order to improve efficiency. These principles were embraced by Tony Blair's 'New' Labour government, where performance management regimes became ubiquitous within the public sector. New Public Management also assumes the responsiveness and flexibility of organisations to be able to effectively engage with top-down performance improvement measures. New Public Management is tied to discourses of consumerism, patient voice and choice, and providing best value for the tax payer. This became a

salient feature of competitive tendering where cost was a key determinant in securing contracts to provide NHS services.

Despite adopting a strategic approach to implementing improvements in line with pre-set top down standards, New Public Management is interesting in the ways through which it proposes to meet its aims. Unlike a traditional Weberian bureaucracy structure typically associated with the public sector, namely a formal hierarchical structure and management by rules, New Public Management aims for flexible rather than hierarchical public sector organisations, with management through targets and performance indicators. The goals of New Public Management are supported by an improved information technology infrastructure and increased computerisation to facilitate the collection and monitoring of performance data.

Therefore, New Public Management signals an indirect rather than direct control (Walsh, 1995). In this vein, it could be argued in line with Carter (1989) that New Public Management created ‘decentralisation downwards, not accountability upwards.’ Managers retain an ownership over performance indicators, which enables them to practice indirect ‘hands off’ control. Financial incentives, designed to motivate professionals, are aligned closely to policy goals of increased efficiency.

Another feature of New Public Management, is the power shift it brings towards managers and away from older established professional groups, not achieved through direct management, but by surveillance and control by indicator-driven performance management frameworks, of which QOF is an example. This has led some commentators to claim that the traditional professional dominance model (e.g. Freidson, 1970), which will be discussed in the section entitled “Professionalism vs. Managerialism”, has been challenged by New Public Management reforms (Hood,

1991; Ferlie et al., 1996). This dynamic has allowed governments to limit the traditional autonomy and power of professionals such as medics, primarily through gaining increased control over their budget decisions. With the introduction of QOF, GPs now had to justify up to a third of their practice's income on the basis of QOF performance, leading to increased transparency over financial remuneration within general practice.

Whilst QOF was initially introduced as a voluntary scheme, practices were unlikely to opt out of a scheme which would account for up to third of their annual income. Similarly, the potential stigma attached to being labelled as a 'poor' performer within publicly available league tables also puts a question mark over the voluntary nature of the framework.

New Public Management reforms promote improved performance within healthcare services by offering financial incentives for meeting pre-established 'quality' targets (Ferlie, 2006), along with an increase in public transparency, and therefore accountability to the tax payer. Indeed, a number of studies have demonstrated that the publication of performance data can play a meaningful role in quality improvement (Marshall et al, 2000).

The drive for improving quality in health services through performance indicators can therefore be understood as a product and tool of New Public Management and the introduction of market incentives to improve the efficiency of public services (Walsh, 1995). New Public Management was embraced by New Labour's White Paper "Saving Lives: Our Healthier Nation" (Department of Health, 1999) and subsequent policy, with the establishment of targets in priority areas to reduce health inequalities.

However, the “Health of the Nation” White Paper of the 1992 Conservative Government upon which ‘New’ Labour’s “Our Healthier Nation” was based, was criticised for not promoting evidence-based targets and data capture mechanisms (Department of Health, 1998). Furthermore, a review of the impact of this earlier White Paper suggests that the engagement of GPs with local quality improvement initiatives was slight, and overall GPs lacked an interest in the ‘bigger picture’ of strategic action nationally. This may be one of the limitations of New Public Management principles, whereby the lack of professional ownership over strategy may result in a sense of isolation from and disengagement from any resulting schemes.

No doubt, New Public Management has paved the way for a culture of increased monitoring and regulation, through the use of electronic surveillance technologies and sanctions in healthcare services, rather than by the direct engagement of clinical professionals. Nonetheless, “Our Healthier Nation” continued New Public Management discourse with the rhetoric of increased accountability through monitoring and evidence-based target-based quality improvement frameworks.

Following on from this policy trend, QOF was conceived in 2004 as part of the new General Medical Services Contract (nGMS) (Department of Health, 2003) and became the dominant model for monitoring the quality of general practice in England on a ‘pay-for performance’ basis. Against the policy backdrop of improving the quality of patient care through measurable targets becoming a key preoccupation within health services (Elwyn & Hocking, 2000), QOF became synonymous with general practice quality in the language of health management and policy-makers. The next section of the

background chapter will explore some the challenges of defining the concept of quality within healthcare.

2.4 Concept of ‘Quality’ in Healthcare

During the past four decades, there has been an intense debate as to what constitutes quality of healthcare, with the search for how to define high quality at the centre of this debate. This section will explore some of the challenges of defining quality and argue that it is short-sighted to let a quantitative target-driven definition of quality predominate.

A definition can be described as a statement which expresses the nature of an entity. Definitions are important as they facilitate a common understanding and uniformity in the conceptualisation of an issue. Being on ‘the same page’ when dealing with a particular problem allows for meaningful interventions, in this case quality improvement and performance management. Accurate definitions are key to the success of such interventions, clarifying how they will work, what benefits they will bring, and make us aware of the benchmarks against which the effectiveness of them will be judged.

There are a number of drivers of the ‘quality agenda’ within the NHS and they relate to public concerns about the quality of medical practice, which are often evident in the mass media. As NHS services are tax payer funded, they must remain accountable to the tax payer and provide value for money. Before the inception of QOF, there was a growing concern about perceived failures of self-regulation post Shipman (a single-handed GP and one of the most prolific serial killers in recorded history), along with a

desire to decrease variation in practice and thus support the goal of reducing health inequalities.

Defining healthcare quality, however, remains problematic. While overwhelmingly quality is presented by policymakers as measurable and as meeting predefined top-down targets, it has been argued that quality in general practice is multiform and multifaceted (Kordowicz & Ashworth, 2013). Quality is a notion that is hugely difficult to pin down in all its richness and complexity and countless attempts have been made at defining quality in healthcare. Definitions range from the more concrete – quality as access and effectiveness for instance (Campbell, Roland & Buetow, 2000) - to the abstract - quality as purely a social construct rather than an objective entity (Harleloh, 2003). Therefore, there exists a clear challenge of bringing together the day to day realities of care delivery within general practice with subjective norms into one construct.

As seen earlier on in this chapter, there is a predominance of numerical information capture within general practice and healthcare more broadly, as part of the increased drive for performance management and quality improvement. Naturally, these types of data lend themselves more easily and more quickly to comparisons against pre-set standards. This facilitates evaluation of services against one another and strategical service decision-making based on quantifiable evidence, which can also be used to evaluate the impact of strategy over time. ‘Softer’ more complex markers of quality of care, such as compassion and the doctor/patient relationship prove problematic in such instances.

QOF is the dominant method of data collection and monitoring in general practice. There are of course a number of benefits to this approach, which will be reviewed in

the subsequent section of this chapter. The problem lies with QOF being perceived as crucial to quantifying quality. Indeed, as demonstrated in the previous section, the policy rhetoric of raising general practice quality through data submission has been wholly embraced by successive governments. Yet, it is likely that instinctively this view feels rather short-sighted to those delivering frontline care within general practice. Policy rhetoric appears to lack an understanding of the complexities of providing quality care in general practice. These complexities encompass a broad range of factors including, but not limited to, the doctor/patient relationship, communication skills, holistic patient-centred care within a biopsychosocial framework and staff team dynamics.

As suggested previously, increased monitoring poses a further challenge for quality capture. The resulting climate of increased bureaucracy, monitoring and surveillance can undermine GPs' sense of professional values, which are strongly linked with 'softer' concepts of quality, for instance altruism and compassion. Nevertheless, Lord Darzi (2008) claimed that 'we can only be sure to improve what we can actually measure' and here again one faces the paradox of quality measurement through reductionist means. QOF is in part guilty of this, with a focus on usable indicators related to outputs rather than outcomes, efficiency rather than effectiveness.

Therefore, QOF implies that quality is an entity which can be meaningfully measured, and that it is synonymous with general practices meeting top-down quantitative targets. In contrast, it can be argued that quality lies on the other end of the quantitative/qualitative spectrum and, according to Harteloh (2003), is socially constructed - held 'in the eye of the beholder'.

Since the inception of “The Patient’s Charter” under John Major, incorporating service user views into quality service provision does demonstrate a greater awareness of the ‘beholder’s’ perspective. It could be argued, that traditionally quality was seen largely in patriarchal terms as, for example, in the definition: ‘degree to which the care delivered is in agreement with medical professional criteria’ (Simons & Van Mansvelt, 1976). Today, the patient voice challenged this traditional patriarchal view and has more prominence in policy design (e.g. by taking on board responses to national patient surveys) and service delivery (e.g. through patient participation groups). Thus, in line with Harteloh’s social constructivist definition, quality is not an objective concept which exists independently of social construction. Rather, quality has an ephemeral essence which changes according to the socio-political context which seeks to define it.

It is these more transient ‘soft’ aspects of what constitutes quality of care in general practice that have posed a challenge for those attempting to define and measure it. Naturally, in a climate of constant performance management, this also renders performance difficult to measure. A recent BMC series edited by Swinglehurst (2015) exploring the meanings of quality in healthcare from interdisciplinary perspectives, highlighted some of these complexities around quality capture. Interestingly, the article collection presented a number of novel ways through which quality can be operationalised in patient care. These, amongst others, include increased awareness of ethical practice through education (Wintrup, 2015), recognising stakeholder perspectives of quality (Millar et al., 2015; Farr & Cressey, 2015) and the use of a community arts project to challenge assumed reductionist meanings of quality in healthcare (Kelly et al., 2015). The role accounting plays in quality improvement and

standardisation within healthcare is explored by Pflueger (2015), who calls for a new system of accounting as applied to health, which will not be for political benefit, but will act for social good through highlighting some of the uncertainties surrounding quality capture. These current academic perspectives do promote a notion of quality which clearly lies beyond basic quantification.

Nonetheless, it is clear, that the performance of general practices and their ability to deliver care which is of high quality has been the focus of public, media and government scrutiny in recent years. Modern general practices have to contend with market dynamics and top-down regulation, and an expectation that they will strive to deliver high quality services to their patients. Indeed, the term ‘quality’ itself has been conceptualised by Heath (2015) as a slogan used to wield top-down power over clinical professionals and the human body as an ‘object’ rather than a ‘subject’ of care.

Furthermore, there are a number of statutory bodies that GPs remain accountable to (e.g. NHS England, Royal College of General Practitioners etc.) in terms of the quality of care they provide and that hold a ‘stake’ in how quality and performance are defined. However, it is worth noting that at the time the fieldwork for this thesis was carried out, the NHS was about to enter a period of unprecedented change under the newly elected Conservative/Liberal Democrat coalition government - namely the implementation of GP-led commissioning and cuts in funding, particularly around management costs. Therefore, the study’s participants must be understood with an awareness of the wider political context of which they are part.

Quality improvement through performance management often assumes uniformity and rationality of the organisation and the actors within it. However, the factors which may impact on the quality of care a general practice delivers are multi-faceted. These factors

could relate to organisational characteristics of the practice itself, or factors specific to the GP. For instance, stress and depression are a well-documented cause of GP underperformance (Cox et al., 2006). A number of features common to low QOF scoring practices have been identified in previous research (Ashworth et al., 2011) and these will be described within section 2.6.

In sum, in order to gain a greater understanding of performance in general practice, one needs to be aware of its multi-faceted nature and the resulting lack of holistic tools for capturing GP performance in its entirety. This thesis is in part a comment on the shortcomings of government-driven top-down targets in truly capturing performance and quality in general practice.

Yet, none of the aforementioned challenges with defining quality preclude the continued drive to raise it within the delivery of healthcare services. However, they strongly suggest that a more nuanced approach to defining healthcare quality is appropriate. It would be of interest to see if the practices participating in this study do indeed demonstrate facets of quality outside of the remit of QOF. It is apt to conclude this section with the following quote, which is reflective of the zeitgeist of continuous quality improvement upon which QOF was launched:

‘The one thing that has remained constant is our aspiration to make quality the organising principle for everything we do. It is a focus on quality that will make services more efficient; that will drive and inspire people to think of new ways to provide care through innovation; and it is a focus on quality that will move the NHS towards concentrating on prevention as well as cure.’

Rt Hon Andy Burnham MP, formerly Secretary of State for Health (2009).

The features of QOF are discussed in more detail in the next section.

2.5 Quality and Outcomes Framework

Here, a comprehensive overview of QOF is given, along with an assessment of its strengths, limitations and impact within general practice.

As previously explained, the dominant paradigm for capturing quality in general practice in England is the Quality and Outcomes Framework or QOF for short, which is a pay for performance scheme, whereby GPs are remunerated for meeting pre-established ‘quality’ targets.

QOF was introduced in 2004, with a budget of £1.8 billion earmarked for the scheme. Targeted payments directly linked to indicator achievement would be made yearly and indicators revised, to ensure continuous quality improvement. Whilst during thesis write up the number of QOF domains had significantly reduced, at the time the study took place QOF covered the following areas:

- Clinical: 80 indicators across 19 areas incl. coronary heart disease; heart failure; hypertension
- Organisational: 36 indicators across 5 areas incl. organisational records and information; information for patients; education and training; practice management; medicines management
- Patient experience: 5 indicators incl. length of consultations and patient survey results

- Additional services: 8 indicators across 4 areas incl. cervical screening, child health surveillance, maternity services, contraceptive services.

As can be seen, general practices would receive payments for QOF points achievement on a variety of indicators in clinical, organisational and patient experience domains – with a 1000 QOF points maximum at the time of the study and a payment of around £120 per point achieved (presently there is a maximum of 559 points available to practices across QOF).

Prior to the introduction of QOF, GPs were paid for list sizes, the number of doctors within the practice and the number and types of services provided. QOF, at the time presented as a voluntary scheme, was to account for about a third of a practice's income and appeared to be a welcome scheme, offering GPs an opportunity for an earmarked pay rise. In 2003, an overwhelming majority of GPs (79.4%) voted to accept the new contract.

Next, the strengths and limitations of QOF will be presented, followed by an assessment of the impact of the framework in general practice, particularly from a qualitative angle.

As far as QOF strengths are concerned, there is no doubt that measurement plays a key part in enabling focused quality improvement initiatives, for instance by identifying need in specific patient populations, and on a wider-level QOF is likely to be a valuable tool in supporting commissioning decisions. QOF consists of targeted payments clearly linked to evidence-based indicators, and is therefore, to use an idiom, not a case of

‘throwing money at a problem’. QOF now holds data for 99.7% of registered patients and has therefore resulted in the creation of the largest general practice database in the world, prompting research around processes and outputs and their relationship to outcomes in general practice. Greatly improved informatics and almost universal computerisation are clear achievements of the scheme.

However, the framework also has a number of limitations. In terms of informatics, QOF itself does not allow for cross-tabulation of data, rendering them difficult to operationalise within research and clinical practice, in particular linking demographics with health outcomes directly within QOF. The accuracy of the data, particularly in terms of disease prevalence within QOF registers has been questioned. As with any data-based framework, QOF is liable to coding errors. The achievement of QOF indicators is linked to Read codes which allow the identification of data. There are numerous codes within each disease area that may be confusing to the GP. When QOF was first introduced, there were variations in codes used to capture performance by different PCTs. The Read code for depression demonstrates this, with the clinician having the option to tick ‘depression’, ‘depressive disorder’, ‘low mood’ and ‘history of depression’, unclear as to which label would facilitate register inclusion and prompts for treatment reviews.

Furthermore, this could be one of the reasons for the mismatch between chronic disease register prevalence within general practice and census data (Martin & Wright, 2009). However, this discrepancy is more likely to be linked to the use of financial incentives within QOF for disease register inclusion. Hope of higher financial reward may

encourage the inclusion of patients with clinical measures on the cusp of diagnostic criteria on a particular chronic disease register. Naturally, over-inclusion has direct implications for the quality of patient care, since it may put patients at risk of unnecessary disease monitoring, and possibly unsuitable treatment interventions.

On the other hand, the process of 'exception reporting' necessarily allows certain patients deemed 'unsuitable', to be excluded from the overall target for patients registered at the practice. Patients may understandably be excluded if they are terminally ill or if they do not agree (after three written requests) to attend an appointment at the surgery for the management of their chronic disease. This suggests that non-attenders will be further excluded from drives to engage patients in public health improvement initiatives. They will therefore be invisible to QOF targets and the public health effectiveness of population targets will be reduced. The overall exception reporting rate for 2008/9 was 6.88% for indicators measuring an outcome and 1.70% for indicators measuring a process. So, on average, almost 7% of patients in England were excluded from public health targets such as achievement of a serum cholesterol of <5mmol/L.

As with other indicator-based incentive schemes, QOF is vulnerable to gaming. Here, Hood's (2006) theory of gaming has been adapted to illustrate the possible gaming strategies that practices may be able to engage in (reproduced from Kordowicz & Ashworth, 2011):

Threshold Effect

Reduction of performance to just what the target requires

- Practices will still be rewarded financially for working to a certain percentage of the target, rather than meeting it for 100% of patients on a given register
- Exception reporting so as to reduce workload.

Ratchet Effect

Underperformance to prevent target increases

- Targets are set nationally and underperformance in single practices is unlikely to influence the level at which a target is set.

Output Distortion

Intentional manipulation of reported results

- A spectrum running from selecting indicators for data entry which fit the target best, through to QOF fraud.

Threshold effects, for instance, could lead to the patient population outside of the QOF thresholds for maximum scores not being included in chronic disease reviews so as to reduce non-incentivised workload for the practice. In the case of distorting the output to fit target achievement best, this may be linked to inconsistent clinical guidance. A blood pressure reading on a patient's electronic notes may be the 'best' of three measurements taken in a consultation, the average of readings taken on separate occasions or even the reading that is closest to the target entered electronically from paper notes by the practice administrator. This is further compounded by the fact that

target levels recommended by the GMS contract differ from those promoted by NICE and the British Hypertension Society. This suggests that defining QOF targets without clear guidance to support them may be meaningless. Therefore, what can appear to be fraudulent data recording may simply be the result of clustering due to unclear methodological guidance.

A further limitation pertains to the apportionment of reward to the indicators themselves, which is overall attached to workload not patient gain. Thus, for example, the indicator DM23 (50% achievement of an HbA1c target for diabetics of 7.0 or less) is awarded 17 points, whereas DM18 (influenza vaccination target of 85% for diabetics) merely attracts 3 points.

In addition, paradoxically, some of the indicators have proven problematic for the quality of care provided to the patient. For instance, in April 2009 GPs were to be rewarded by QOF for reducing glycated haemoglobin in half of their patients with type 2 diabetes to below 7% to earn the same amount that they were paid for achieving a target of 7.5% previously. Reducing glycated haemoglobin below 7% is not supported by evidence and could potentially be put patients at risk (Lehman & Krumholz, 2009). The tightening of this indicator was later withdrawn. It is also worth adding that QOF may reduce the focus from non-incentivised domains, such as gastrointestinal and rheumatological disease which were not captured by QOF at the time of writing.

Finally, as explored throughout the course of the thesis, the dominant criticism of QOF is that it does not capture the qualitative domains of excellence, such as rapport, compassion and consultation skills. To offer a balanced view, the qualitative impact of QOF will be elaborated upon next.

The Impact of QOF

In order to avoid some of the pitfalls of a purely reductionist approach to quality discussed earlier, the qualitative impact of QOF within general practice will take predominance in the following analysis.

Overall, general practitioners have been supportive of the QOF target regime (McDonald, 2014). Generally, doctors appear to have welcomed the new structures and better organised working practices implemented as a result of QOF, which may explain their acceptance of the scheme nationally. However, a select few practices have underperformed on QOF year on year, suggesting that there remains a small handful of practices which have not embraced the scheme.

According to a study by Grant and colleagues (2009), the introduction of QOF led to a number of positive organisational changes, particularly due to improved IT systems and a more organised managerial infrastructure within the practices. This could perhaps be an indication to some of the managerial principles of QOF becoming internalised by general practice. Additionally, the authors indicated that QOF also brought about a shift in professional boundaries, whereby practice nurses gained greater ownership over reviews for specific disease areas.

However, studies have also revealed a dramatic increase in workload since QOF's introduction, particularly for practice nurses (O'Donnell, Jabareen & Watt, 2010), with a lower than expected remuneration in relation to the financial rewards for the practice. Nurses were also feeling frustrated due to the adherence to 'box-ticking' imposed by QOF, which undermined the person-centred nature of the nurse-patient consultation.

Employing an ethnographically-informed organisational case study design, Checkland and Harrison (2010) drew conclusions as to the impact of QOF on service organisation and delivery. Practice organisational structures shifted in terms of the adaptation of roles, with practice nurses holding new control over long term conditions indicator performance, and in terms of a new stronger IT infrastructure (supported through additional PCT funding) to manage the implementation of QOF within the practice.

Notably, QOF has led to near on universal computerisation of general practice in England, creating the largest primary care database in the world. It is worth noting, that there appears to be a link between the type of ‘inpractice’ IT system and practice QOF performance (Kontopantelis et al., 2013), which suggests that QOF performance is heavily influenced by successful IT navigation, rather than purely the ‘on the ground’ performance it is designed to capture. Checkland and Harrison note that QOF led to the introduction of greater monitoring and surveillance. Interestingly, the practices included in this study claimed that they had not undergone change in terms of performance and rather QOF had easily fitted their existing organisational paradigm.

Whilst there is a prominent body of literature arguing that increased managerial interventions undermine clinical professionalism and therefore should be resisted (e.g. Freidson, 1985; Mangin & Toop, 2007), in contrast Harrison and Checkland’s findings point towards the development of a new status quo where surveillance is regarded as legitimate and a necessary tool in quality capture. However, that may only be the case for practices which engage with QOF. To gain a broader view of responses to increased surveillance through QOF, it is of interest to also explore the characteristics of practices which continue to underperform on the framework. This continued underperformance may indeed be a marker of low practice quality and no improvement over time. But, it

could also signal a lack of engagement with QOF and a resistance to QOF surveillance. These concepts will be explored further within section 3.2.

An unpublished meta-synthesis of papers relating to the qualitative impact of QOF was undertaken by the author of this study in 2010, to help narrow down its research focus, whilst the thesis was still very much in its infancy. A systematic search of electronic databases was carried out using the search terms ‘qualitative’, ‘general practice’, ‘quality and outcomes framework’ and ‘pay for performance’. English language papers using qualitative methodology only, conducted in an English general practice setting and concerned with the experiences and impact of QOF in general practice post its introduction in 2004 were extracted.

Initially, after the removal of duplicates, 100 potentially relevant studies were identified. The abstracts of these were assessed against the inclusion criteria and nine papers were found to be appropriate for meta-synthesis. The quality of these papers was judged to be acceptable for inclusion using the Critical Appraisal Skills Programme (CASP) quality assessment tool for qualitative research (Public Health Resource Unit, 2006). Finally, nine qualitative papers (McDonald et al., 2007; Rycroft-Malone et al., 2008; Campbell et al., 2008; Maisiey et al., 2008; Checkland et al., 2008; McDonald et al., 2008; McDonald et al., 2009; Grant et al., 2009) were synthesised.

It was of methodological interest to the PhD that the use of ethnographically-informed observation appeared to be limited in the synthesised studies and utilised in some simply to support or refute interview data. In contrast, this study aims to enrich this methodological approach by bringing together interviews, field-notes from observation and documentary evidence to form cohesive case studies of ‘poor performing’ general practices (see Methods section for more detail). Overall, the findings of the meta-

synthesis supported the notion that QOF had an impact on organisational facets of general practice, highlighting the saliency of studying organisational responses to QOF.

The synthesis further suggested that QOF was a 'mixed blessing', having had both negative and positive influences on general practice. Negative influences included the introduction of a 'tick-box' medicine approach to care and a lack of person-centredness, with patients reportedly being treated as algorithms because of QOF's implementation. The meta-synthesis also revealed some tensions stemming from what was perceived to be a fine line between PCT supportive feedback and intrusive monitoring of the practice, again pointing towards the importance of considering the theme of surveillance when understanding QOF's impact in general practice. Monitoring which was perceived by the participants of the studies to be excessive tended to lead to frustration and loss of motivation. This can be linked to classic psychological literature concerning the role of incentives and monitoring in intrinsic and extrinsic motivation, whereby increased surveillance leads to a loss of interest in the task at hand, particularly when it is rewarded externally (Greene & Lepper, 1974). Further, this is in keeping with the argument that quality improvement initiatives such as QOF have to appeal to intrinsic professional values to maintain long term clinician motivation and cannot rest their success solely on financial rewards. It has also been suggested that monitoring quality improvement through professional networks of clinicians, rather than by external regulatory bodies, leads to greater affiliation with initiatives (Sheaff et al., 2004).

Positive influences of QOF highlighted by the meta-synthesis, centred on the improved organisation of the practice, driven by the IT infrastructure put into place alongside QOF and the clearer split of QOF clinical responsibilities between GPs and practice

nurses. The findings of the meta-synthesis suggested that the hopes for QOF bringing with it an improved IT infrastructure and better role definition and team working have largely been realised.

The meta-synthesis was an important preliminary step in providing a rationale for this thesis. It became clear that the organisational dynamics behind measurable quality indicators are of interest to both clinicians and policy-makers, particularly in light of what makes the implementation of QOF acceptable to practice staff. For instance, it is of relevance to both managers and policy-makers that there appeared to be a fine line between surveillance and feedback in terms of motivation to perform on the QOF. The findings of the meta-synthesis suggested that excessive monitoring may lead to a frustrated workforce, whereas role clarity, target ownership and regular feedback have the potential to build trust and motivation.

It was recognised that the meta-synthesis offered a useful starting point for understanding what makes quality improvement initiatives impact positively on general practice. This thesis builds on this recognition by presenting a study of practices selected on the basis of their QOF scores, to gauge whether or not particular responses to the implementation of QOF may have a detrimental effect on QOF performance. Undertaking this research has the potential to fill a gap in the literature highlighted by Glickman and others (2009) – namely that we know more about how quality improvement initiatives affect the organisation and less about how the organisation affects the success of quality improvement initiatives.

To focus on the impact of QOF more broadly, what of the measurable elements of quality that QOF actually purports to measure? Have there been positive improvements in terms of the quantifiable face of general practice quality? There was some clear

evidence of public health gain in the domain of diabetes management and cardiovascular risk factors in diabetic patients (Millett et al., 2007). Furthermore, a narrowing of difference in QOF achievement between deprived and prosperous areas was demonstrated over time (Ashworth et al., 2008). In fact, the greatest improvements in QOF performance in specific indicators were seen in deprived communities (Lester, 2008), suggesting that QOF was an effective tool in the drive for reducing health inequalities.

In addition, smallest practices improved their QOF scores at the fastest rate and by year three had the highest median reported achievement rates of 91.5%. As small practices were represented among the highest and lowest QOF scorers, the authors of that specific paper concluded that QOF appeared to have reduced variation in performance and the differences between large and small practices also (Doran et al., 2010).

It is worth noting that in the first year of QOF the mean score nationally was an unexpectedly high 954.2/1000 points. This suggests that QOF may have simply captured high performance that was already in existence, rather than leading to tangible improvements. In line with this, an independent enquiry carried out by the King's Fund (2011) concluded that there was insufficient evidence that financial incentives for GPs have improved national health overall. Whilst echoing Lester that practices in deprived areas improved more on specific QOF indicators than those in the least deprived, the report also highlights that their overall achievement was still lower than that of less deprived area practices. Unlike Lester therefore, the report does not suggest that QOF can be a driver of the reduction of health inequalities, rather that there is limited evidence of the direct impact of QOF on improving health or reducing health

inequalities. This report finding was linked to QOF not providing incentives linked to public health outcomes.

One of the few findings within the King's Fund report in support of QOF, was that the framework was seen as effective in helping practices to implement improved approaches to secondary prevention. Furthermore, practices with an effective organisational and staff infrastructure were identified by the report as being more likely to be rewarded well by QOF. This implies that practices in deprived areas which may already be under-resourced, are likely to not do so well overall due to their poor organisational infrastructure. This finding highlights the need to study the impact of QOF on an organisational level.

Yet, the research reviewed here did not explore the impact of QOF on the persistent low scorers. Indeed, practices which appear to remain outside of the reach of performance management frameworks may react quite differently to them. The premise of this thesis is of course to gain a greater insight into those general practices. The next section will highlight further why this particular group is of research interest.

2.6 Persistent Low Scorers

A group of persistent low scorers was identified by Ashworth and colleagues (2011). How this was achieved will be discussed in detail in the Methods section. Throughout the review of the background so far, it has been implied that this cohort of general practices would be of particular research interest, due to their outlier nature and seeming lack of engagement with QOF. It is likely that much of the aforementioned

changes brought about by QOF cannot be generalised to the cohort of consistent low QOF scorers.

It would be thought-provoking to gain an understanding of why certain practices consistently underperform and whether the causes of their low QOF scores are similar across all cases of the participating low scorers. Furthermore, an insight into why certain general practices apparently remain immune to performance management through QOF would be of value to policy makers and managers, who could adapt their interventions to gain 'buy in' from these outliers.

To date 'poor' performing general practices have not been studied qualitatively. However, a previous study has attempted to capture the qualitative characteristics of poor performing hospitals (Mannion, Davies, Marshall, 2003). The conclusions of the study suggest that the findings of this thesis may concern concepts of management, accountability and the use of information systems to name but a few. These concepts appear to be relevant to the level of organisational performance in light of quality improvement schemes and performance monitoring.

This section is intentionally kept brief, so as not to make assumptions about the low scoring cohort. Rather, the study will seek to get a greater understanding of its participants through the data generated throughout the research process. The next chapter of the thesis will assess the potential theoretical frameworks that can be applied to enhance this understanding. Theoretical constructs of professionalism and managerialism, along with responses to surveillance, will be put forward as potential frameworks for aiding understanding as to the dynamics that underpin the successes and failures of incentive-based quality improvement schemes. It is likely, that a group of consistent 'poor' performers may help to develop these constructs to encapsulate

responses to QOF which are unusual in comparison with general practice in England overall, considering that the majority of practices perform exceptionally well on QOF.

3. TOWARDS A THEORETICAL FRAMEWORK

This study will draw on pre-existing knowledge throughout, in order to provide a framework – building on past concepts and literature to potentially develop new understandings. It is hoped that the frameworks used will shed light on understanding low QOF scoring practices and will guide the best methodology for this purpose. Concepts which can potentially be used to understand and define why a select group of general practices would persistently end up with lower than average QOF scores are reviewed. This enables movement beyond basic description to in-depth description, interpretation and analysis, with potential explanations for observed phenomena offered by proposing potential theoretical frameworks.

To contextualise this statement within health services research, Crabtree and Miller (1999) argue for greater inclusion of theory in the study of general practice. They state that traditionally general practitioners do not work with abstract concepts, rather specific factual information. Yet, we shouldn't assume that a quantitative approach of this nature is the only lens through which to view the world. For instance, theoretical understandings stemming from qualitative enquiry about patient/doctor relationships, and how they affect engagement with treatment, are also key to a successful patient outcome. Furthermore, Kelly (2010) promotes the use of theory at the planning stage of qualitative research, hence these chapters are exploratory in nature, enabling the planning of this study. It is not unusual, however, for researchers to iteratively go back and forth between the literature, research questions and research findings throughout the course of their study and this is the approach taken throughout the course of this thesis.

3.1 Professionalism vs. Managerialism

‘The role of the family doctor is in part to protect the patient from the excesses of specialized technocracy; to defend him against narrow mindedness; and to help him humanely to find his way among the complex maze of scientific medicine.’

Richard Titmuss, *Commitment to Welfare* (1968)

Professionalism stands out as one of the key policy discourses in the present government White Paper ‘Equity and Excellence: Liberating the NHS’ (Department of Health, 2010). The White Paper promises to empower healthcare professionals, to liberate them from excessive state interference, stating that they are best placed to make decisions about how the NHS is run. It claims that bestowing this freedom and trust upon professionals will lead to better quality patient care. This policy sentiment suggests the existence of an interrelationship between the state and healthcare professionals. In light of this, the potential tension between state governance (i.e. QOF) and general practice will be explored in this chapter. The supposed strengths, as well as limitations, of professionalism in facilitating health services quality will also be examined. The overarching purpose of this chapter is to introduce professionalism and related themes as one possible explanatory framework for understanding general practices with low QOF scores.

An interest in the nature and role of the professions is not new. Johnson, writing in 1972, argued that the professions are assumed to hold unique characteristics which distinguish them from other occupations. This assumption of uniqueness in turn

provides a justification for the distinct body of theory ‘the sociology of the professions’. Within this discipline, attempts at defining professionalism have been explored. In its most basic sense, professionalism can be defined as the length of formal training and experience of employees (Daft, 2001), though this may be overly simplistic. In contrast, Friedson’s (1994) thirty page chapter in his seminal work “Professionalism Reborn”, seeks to find an appropriate definition, but concludes with an argument against defining something so complex and evolving.

However, some commentators have proposed lists of the qualities of professionalism as useful definitions. In 1994 Sir Kenneth Calman, then Chief Medical Officer, published a paper in the British Medical Journal in which he argued that it was important to consider defining the facets of professionalism in a time of ‘questioning of professional standards and the quality of care’ and that the medical profession should espouse the following values:

- Driven by a sense of vocation or calling, implying service to others
- Has a distinctive knowledge base, which is kept up to date
- Sets its own standards and controls access through examination
- Has a special relationship with those whom it serves
- Is guided by particular ethical principles
- Is self-regulating and accountable.

Professionalism is a concept that is familiar, yet complex, resulting in differing understandings of its meaning. Professionalism might simply imply a positive feeling and attachment to one’s vocation. For instance, Newkirk (1982) defined professionalism as ‘the quality of an individual to overtly display characteristics that

positively represent the standards of one's profession and a commitment to advancing the program or activity of the profession.'

Furthermore, an understanding of the root word *profession* is required before exploring the behaviors that characterize professionalism. Three suggested fundamental elements of a profession (Adapted from Brown, 1971) are as follows:

- *A value orientation to service* for the welfare of society/service orientation/welfare of others is uppermost
- *Abstract knowledge used adaptably and skillfully* in the area of service/expert knowledge for the service/a theoretical framework
- *Autonomy in decision-making and action* relative to the service/decisions are made and actions taken based on expertise, knowledge and reason.

These characteristics must be translated by individuals into *patterns of action* that convey the image of a professional person, suggesting that professionalism refers as much to a code of conduct, as to the traits of an individual or group. However, a common critique of attempts to define these traits is that they are based on a flawed assumption that professions are internally homogenous. Indeed, social groups have been observed to demonstrate intra-group variations in behaviour (Traindis, 1989). Similarly, it would be naïve to assume that all general practitioners conduct themselves in the same way, across all situations.

However, given this relatively ambiguous and qualitative nature of the facets of professionalism, whilst conduct may be variable, there is clearly a push for a commonality of values to underpin the general practice profession. In addition, a general practice holds values as an organisation. Organisational values define the

acceptable standards which govern the behaviour of staff within the practice. Without such values, individuals may pursue behaviours which are in line with their own, rather than the practice's value systems. Yet, it is worth noting, that the values of external organisations providing a mandate to the practices, may be at odds with the professional, and autonomous by their very definition, values of the general practitioner.

Further discourses surrounding the professions explore the notion of governance and power within them. Professions can be viewed as networks with the goal of the preservation of social standing, unique expertise and power at their core (Rogers & Pilgrim, 2001). As such it serves the professions to become penetrable only through a strict and lengthy initiation process; years of education and training and membership of accreditation bodies in the case of medicine. The values that underpin their conduct, may also influence how the professions govern themselves internally. It could be argued that there is a level of collegial pressure, only 'a quiet word' uttered, as a mode of self-surveillance through semi-formal networks within the medical profession (Sheaff et al., 2004). In his seminal book "Profession of Medicine: A Study of the Sociology of Applied Knowledge", Freidson (1970) explored the medical profession's history and internal dynamics. In "Doctoring Together: A Study of Professional Social Control" (1975) he expanded on his observations and concluded that doctors have no effective way for disciplining members of their own profession for misconduct or malpractice and instead they have an unspoken and unofficial mechanism of steering patients away from poor performance.

However, professional standing and belonging to a professional group bestows the power to block change (Ferlie et al., 2005) and professionals must be engaged in a

change process in order for it to be implemented. Policy makes the assumption that professionalised organisations are flexible and responsive to change. Yet, Weberian arguments, at odds with principles of New Public Management, propose that organisations maintain an authority to block change through their bureaucratisation and thus nurture an internal governance based on discretion and abstract knowledge. This conceptualisation can be tied in with ideas about the distribution of power within organisations, with power very much resting at the operational core of the general practice. Mintzberg (1983) saw the professional bureaucracy as a system of expertise, whereby the organisation relies on highly trained employees to achieve its mission. This can be linked with Foucauldian view of professionalised organisations as distinct concentrations of power, with knowledge a means by which power is wielded (McKinlay & Starkey, 1998). Friedson (1994) develops this argument by asserting that there will always exist a dependency on specialised bodies and therefore expert organisations, with their monopoly of knowledge, are a necessity. In this way, the continued existence of professional silos of power becomes justified.

Additionally, through the application of Mintzberg's ideas to health ministries, Unger and colleagues (2000), argue that the lack of evaluation of outputs in the professionalised organisational model leads to high healthcare costs for the organisation itself. It follows, therefore, that a pay for performance system such as QOF which standardises and evaluates a large chunk of a GP's workload plays a key role in reducing the costs of care, albeit in part through a process of deprofessionalisation, whereby some clinical expertise is removed from silos of professional power and delivered through IT systems.

Unger and others suggest that the drive to conserve the prestige and decision-making freedom that a professional bureaucracy brings, is detrimental to the organisational elements of a health body, leading to further service inefficiency. It is, therefore, of particular interest to study those longitudinally low scoring practices which appear to resist QOF, to test the assumption that professional structural models will have inefficient organisational practices.

Professionalisation is thus often presented as being at odds with managerialism, which, as discussed in previous chapters, promotes standardisation to eliminate unnecessary variation in conduct and service delivery. The use of incentives to promote this standardisation, can again be viewed in Foucauldian terms as ‘governmentality’ or the techniques by which medical networks of power are rendered governable and governed by state bureaucrats. This in itself is an external form of control and, in the 1980s and 1990s, Freidson warned of increasing bureaucratisation as a threat to the independence of the professions and cause of the erosion of doctors’ autonomy.

Nonetheless, it would seem that professional values provide an important function in society today – they suggest an ethos of altruism and service to others. The notion of the professional as an ethically driven public servant is not a recent one. In 1933, Carr-Saunders and Wilson described the professions as providing moral stability to society and that by preserving tradition they ‘stand like rocks against which waves raised by these forces beat in vain’. To take this analogy further, the “Liberating the NHS” White Paper suggests that the key to improved healthcare is to reduce the assault of negative forces, namely ‘political micromanagement’ through the reduction of bureaucratic burden, supposedly allowing clinicians to ‘stand like rocks’.

Indeed, state-imposed bureaucracy has been an ongoing theme in the study of professionalism, often presented as a threat to the stability and dignity held by the professions. Almost twenty years after Carr-Saunders and Wilson so eloquently expressed their support for the professions, Lewis and Maude (1952) identified British governmental officialdom as a key risk to the correct functioning of the professions. In this vein, the noted sociologist C Wright Mills (1951) warned of ‘managerial demiurge’, whereby the manipulative politics of management practices steal power from the professions, leading to a society governed by coercion and yoke. Clearly, there is a sense of professions needing to remain independent of the control of the state in order to maintain their status. Therefore, routinisation and bureaucratic control, of which QOF is but one tool, can be seen as gradually eroding the expertise of the professions. This can be best described within the context of deprofessionalisation, implying a helplessness of the professionals to these external state forces.

Today, the tension between bureaucracy and professionalism remains a central theme in the study of GP performance management. A provocative opinion piece by Mangin and Toop (2007) presented QOF as signalling the loss of GP independence to the external forces of the state. They warned that QOF, based on the premise that GPs are motivated by financial gain, rather than the wellbeing of their patients, would erode the trust between the public and the GP profession.

At core of the bureaucratisation of medicine versus professionalism argument, notions of medical practice and professionalism as complex entities require attention; they are both constructs which cannot ever be completely captured as a series of measurable outputs for the purpose of external monitoring and financial reward. Mintzberg (1983) claimed that due to its complexity, an organisation’s outputs cannot ever be truly

standardised. As covered in earlier chapters, one could take this further, and argue that healthcare provision is uniquely complex and therefore attempts at distilling it into measurable outputs are futile. Due to its inherent complexity, healthcare should remain ‘professionally-owned’.

It follows, that this is often the argument posed by QOF’s opposition. As discussed previously, Iona Heath and colleagues (2009) argue for medical holism over QOF. Furthermore, in line with Sir Kenneth Calman’s characteristics of professionalism, QOF undermines a professional’s power to dictate their own standards (Mangin & Toop, 2007). Yet, such counterarguments to QOF could also be seen as a means of legitimising non-conformity with state rules, in order to maintain professional power. There is some evidence from ethnographic research that claims of professional clinical judgement are often used to normalise breaking rules (Dixon-Woods, 2010). To take this further, this process of legitimisation may not necessarily result in better more patient-centred care, but rather act as an excuse for not engaging with QOF. These ideas could be applied to low QOF scoring practices, whose low scores are the result of a lack of engagement with the quality improvement initiative. Such practices may justify their rejection of QOF through asserting their professional values of patient-centeredness over the tick-box pay for performance approach of QOF.

Yet, it is also worth noting that as GP practices operate as small businesses, an outright rejection of financial gain over patient-centred care is thus an oversimplification. And indeed in order to survive and to keep providing quality services to their patients, a GP practice must retain an income stream, which requires some conformity with state administration. Therefore, it would be of interest to explore how the low QOF scoring practices rationalise these conflicting values in the face of state bureaucracy. The notion

of professionalism, and perhaps other values, influencing the level and type of engagement with QOF is an interesting premise.

The dichotomy of state bureaucracy versus GP professionalism is not perfectly clear cut. Whilst a question mark is raised over the extent to which GPs can remain truly autonomous in the face of QOF monitoring, Friedson (1970) suggested that doctors are entirely subordinate to the state in terms of the social and economic constraints of their work. In Friedson's view doctors retain control over the technical aspects of their work, but it may well be that such autonomy and monopoly are only possible because of their dependence on and sponsorship by the state (Larson, 1977). This was termed 'organised autonomy' by Friedson, a mandate bestowed by the state upon the professions to control their own work.

In other words, the professions only remain so because of the recognition they are given by state institutions. This is in keeping with Michel Foucault's (1973) studies of the interaction of the state and medicine, where modern professions are constructed as a product of governmentality. Although this is a complex notion, warranting its own thesis, within this framework GPs can be conceptualised as tools of the state used to enact government policies. Thus GPs are only officially recognised as experts in order to be given the remit to facilitate the implementation of government agenda.

It would certainly be of interest to explore the relationship of low QOF scoring practices with state controls, and the extent to which they feel that their professionalism is undermined through QOF. Qualitative studies in existence at the time of writing, do not indicate a loss of GP autonomy, or QOF undermining clinical decision-making for that matter, rather QOF has been credited with increasing professional power amongst other general practice staff members, namely practice nurses and healthcare assistants

(e.g. Checkland & Harrison, 2010). One study exploring the influence of bureaucratic controls in general practice suggests that the impact of bureaucracy on GPs may be exaggerated and its effects dependent upon their place within the organisational hierarchy (Boreham, 1983). So while the work of specialists lower down the organisational hierarchy (e.g. salaried GPs, practice nurses) may be becoming increasingly routinised through QOF, professionals in senior positions may still be able to retain their autonomy and professional control. This is because the general practice continues to rely on their clinical expertise.

This suggests that it is important to have an awareness of the internal distribution of power within a general practice if one is to study the full interrelationship between professional autonomy and bureaucratic control. Some commentators have argued that professional autonomy is contingent rather than fixed (Harrison & Dowswell, 2002), implying that inflexible top-down management frameworks therefore go a long way to undermine it. Here, clear parallels can be drawn with Mintzberg's characteristics of the professionalised organisation. In order for this structure to be effective, the professionals at the helm of it should retain their autonomy and power. Because their power is distributed down through the hierarchy, professionalised organisations are difficult to change. This no doubt holds implications for how general practices react to government monitoring.

It appears therefore, that professionals in senior hierarchical positions can still manage to resist the encroachment of bureaucratic controls and managerialist ways of thinking into their specialist domains. This may to some extent explain why low QOF scoring practices tend to be single-handed (Ashworth et al., 2011). Within this framework, it may be easier to resist QOF as the sole senior figure in an organisational hierarchy,

without the normative effects of a partnership or group. On the other hand, a lack of normative influence in general practice can be detrimental to its performance and the quality of care it provides (Campbell et al, 2009). Conversely, patients may prefer the personalised care offered to them by a single-handed practice. It may be found therefore, that the underperforming single-handed practices studied for the purpose of this thesis may continue to deliver person-centred care in spite of their low QOF scores.

The Shipman Inquiry (2002-5, sourced from The National Archives) – an extreme case of a single-handed GP's abuse of power – resulted in a recent call for greater GP professionalism. The Inquiry emphasised increased accountability through self-regulation. Yet, there is perhaps an inherent paradox here. Citing the Harold Shipman malpractice scandal, Randall and Munro (2010) argue within a Foucauldian framework, that there exists an illogicality whereby abuses of professional power such as Shipman's result in even greater calls for 'professionalism'. Although an extreme example, clearly the Harold Shipman scandal calls into question the notion of professional power as the key to achieving quality patient care. On the other hand, such events can lead to cries within professions for better self-regulation, as well as a recognition of the limitations of professional knowledge.

Therefore, the desire to preserve professional power can be a limiting factor in improving patient care, and certainly in implementing government policy successfully. This may well be the view taken by policy-makers calling for greater GP accountability and transparency through QOF monitoring and publicly available QOF ratings. Furthermore, it is clear that consistently low scoring practices react to QOF monitoring in a unique way – they appear to remain in opposition to this form of surveillance, or at least disengaged from it.

Managerialism creates a negative culture of ‘bureaucratic accountability’, achieved through external surveillance. GPs may be critical of this situation, but are viewed as demonstrating little resistance to it (Harrison & Dowswell, 2002). Increased monitoring poses a further challenge for quality capture. The resulting bureaucracy and a feeling of being ‘watched’ can lead to GPs’ sense of professionalism being undermined. It is not a new point of view that potentially reducing patient care to a ‘pay for reporting’ approach can be demotivating and even reduce quality in non-incentivised areas (Kordowicz & Ashworth, 2013). The next section in this chapter will explore notions of surveillance in more depth.

3.2 Regulation & Surveillance

‘The first task of the doctor is ... political: the struggle against disease must begin with a war against bad government.’

Michel Foucault (1963)

This part of the theoretical literature review will demonstrate that, in the context of a Foucauldian framework, QOF can be viewed as an electronic surveillance technology within general practice. Potential GP responses to regulation through surveillance will also be explored.

Foucault’s theory of power and concept of governmentality were touched upon in the earlier chapter on professionalism. It is by refining his theory of power, through his studies of the interaction of the state and its subjects, that Michel Foucault developed the notion of governmentality (Foucault in Burchell, Gordon & Miller, 1991). Here, he

moved away from the traditional understanding of power as lying within the apexes of societal hierarchies. Rather power, as discussed previously, is presented as becoming internalised by professional strongholds through knowledge. According to Foucault, power lies in a loose ensemble of the state and expert groupings, within what he termed a power/knowledge nexus. The medical professional can be viewed in the context of an existing part of this wider nexus, whereby their power is, to an extent, at the mercy of state apparatus.

Thus, the knowledge that professional groups are recognised as experts by the government, conversely leads to more effective forms of social control. In Foucault's view, this is because knowledge enables individuals and groups to govern themselves. To apply this to the professions, by recognising certain groups as holding professional power, the government renders them officially capable of enacting government policy. Therefore, the ways in which the professions self-govern are tacitly infiltrated by government influence. Furthermore, knowledge facilitates the creation of self-ruling and auto-regulated groups, resulting in 'the formation of a whole series of specific governmental apparatuses' (Foucault in Burchell, Gordon & Miller, 1991).

Foucault's ideas are often cited and rarely critiqued. Marxist critiques relate to the notable absence of economic and capitalist considerations within his frameworks and there are also feminist critiques in existence (see Martin, 1982). A review of the literature reveals that the main criticism of the concept of governmentality is that it is at times defined with undue complexity. One commentator described Foucault as the archetypal post-structuralist philosopher – prolific and impenetrable (Wood, 2003). Indeed, for the sake of brevity, it is not appropriate to unpick this complexity here. To counteract this claim, it is worth noting that Foucault's concepts have proven highly

operationalisable (e.g. Miller & Rose, 2008). In this thesis, elements of the definition of governmentality and his notions of surveillance, which illustrate how QOF can be viewed as a surveillance technology, are expanded upon. But perhaps the simplest definition of the concept could simply be ‘the way people are governed to exercise political power.’

Governmentality can thus be understood at its most basic level as the means through which a government fulfils its policies and governs its citizens. It also spans the strategies that are employed by the government to render its subjects governable and how best to mould society into enacting its policies. Foucault saw modern professions as a product of governmentality. Applied to general practice, GPs are granted the power of belonging to a professional group in order to be given the remit to enact government policies. Thus, in this context, GPs are utilised to enact government policies, and achievement of this is continuously monitored and regulated.

Furthermore, as general practices have been structured as small business entities since the inception of the NHS, and GPs continue to work as contractors to the state, it is apt to refer to Foucault’s notion of ‘neoliberal governmentality’. Here, within the liberal democracy of England, power is devolved and its citizens play an active role in their own self-government. Neoliberalism is characterised by the predominance of market mechanisms, which as previously discussed, were introduced by the Thatcher government into the public sector and continue to feature strongly within the modern NHS. Thus as independent contractors, GPs are given remit to self-regulate and auto-correct, but not without government surveillance and sanction.

As was touched upon in the previous chapter, in today's public management, one key tool to achieve the aim of monitoring is the use of electronic systems. Therefore, it can be argued that QOF is a means through which the government monitors the standard to which GPs 'perform' the task of enacting their mandate. In the case of QOF, this is achieved by the infiltration of 'inpractice' computerised systems through QOF Read clinical encoding, templates and reminders flagged automatically during consultations, as well as data submission through the GP payment calculation system (previously GMAS and now the Calculating Quality Reporting Service). The use of incentives to promote this standardisation, can again be viewed in Foucauldian terms as a facet of governmentality, or the techniques by which medical networks of power are rendered governable. This is achieved by an external form of bureaucratisation with the potential to erode doctors' autonomy, as was elaborated upon earlier in the chapter.

In addition, each practice's data are made publicly available, opening the practice up to scrutiny. Though a distinct model in itself, which will not be explored as part of this thesis, it is nonetheless apt to view this as a product of what Dunleavy and colleagues (2005) coined 'digital-era governance', whereby professional groups are placed under close monitoring. QOF can therefore be conceived of as a technology of power, utilised for surveillance.

Indeed, the rise of modern surveillance technologies have perhaps made Foucault's concept of the Panopticon even more relevant in the study of the interaction of the state with its subjects. Foucault utilised the Panopticon as a metaphor for the operation of power and surveillance in modern society. The Panopticon was an architectural structure, created by Jeremy Bentham in the 19th Century, primarily for use in prisons and mental asylums. Its purpose was to replace violent methods of regulation with

constant observation; an internalised coercion, whereby inmates were monitored unceasingly from a vantage point within a high central tower. No communication or interaction between the inmates was permitted. Parallels with QOF can easily be drawn, whereby in a neoliberal market where competition between GP practices is encouraged in terms of reaching high QOF scores, practices seek to moderate their behaviour very much in isolation. The belief that one is under constant observation and scrutiny, leads to increased control of the subject through a rise in self-monitoring. Simply put, the awareness of being watched influences one to moderate their behaviours. Surveillance therefore promotes reformed conduct and obedient subjects, which internalise the new imposed behaviours.

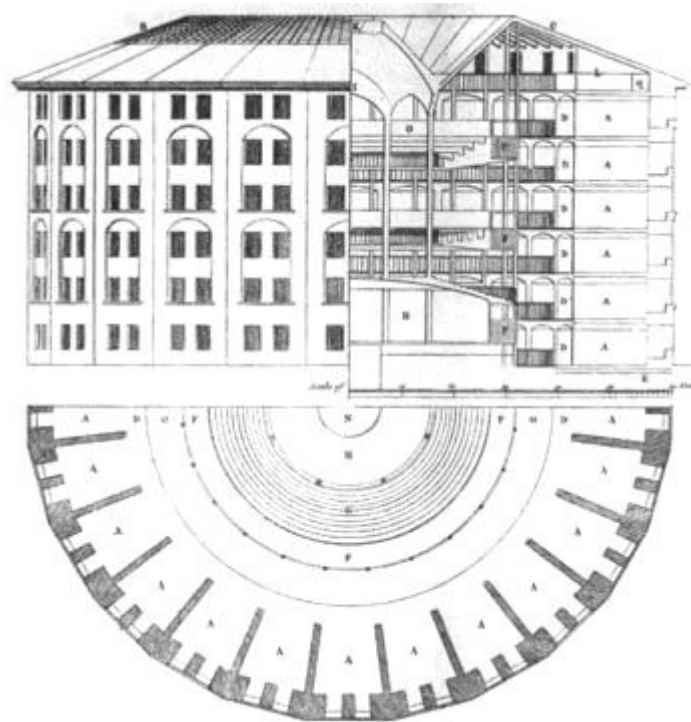


Figure 1: Foucault's Panopticon

The Panopticon metaphor suggests that power and knowledge are produced by observing others, supervising and recording events. This surveillance is internalised, resulting in the acceptance of rules and a passivity in the inmates, identity shifts and the creation of a new and reformed self (Starkey and McKinlay, 1988). This reaction, desired by the observer, is rooted in the looming threat of discipline. This analysis suggests that day to day technologies of pervasive surveillance may act as a source of discipline and eventually encourage the observed to adopt reformed conduct, although resistance to the control regime remains possible.

Thus, the more one observes, the more power one gains (Foucault, 1975). Therefore, the proliferation of QOF targets, with the growing level of detail required from the GP in order to meet them and achieve an incentive payment, can be seen within this framework as the quest of the government for more power over general practitioners and professionals more widely. This is captured by what Foucault described as the observers' drive for more power through 'new objects of knowledge over all the surfaces on which power is exercised'. Therefore, self-surveillance is a product of surveillance, whereby individuals make an assumption that they are being observed, and as a result begin to subconsciously police their behaviour, aiding the implementation of policy.

In line with this assumption, in the context of the regulation of the medical profession through patient safety policy, Waring (2007) argues that doctors seek to subvert government managerial reforms through ownership of components of those reforms to reinforce claims to medical autonomy. This take develops the Foucauldian concept of internalisation. Waring describes this acceptance and normalisation of policy by the medical profession as 'adaptive regulation' in order to reduce the encroachment of

managerialism and to maintain professional power. However, according to Waring, this rebellion of sorts ‘leads to new and rearticulated forms of self-surveillance, self-management or ‘governmentality’, ultimately negating the need for external groups to explicitly manage or regulate professional practice’. This suggests that choosing to implement policy may simply be a move amongst clinical professionals to get managers ‘off their backs’.

In a similar vein, Sheaff and colleagues (2004) analysed the development of clinical governance systems in primary care, seen as a shift away from self-regulation which has traditionally been strongly developed in general practice. Using a Foucauldian framework, the authors suggested that the internalisation of clinical governance discourse could be seen as a way of promoting self-surveillance and self-discipline linked to value shifts among primary care doctors, who were a group most difficult to control through direct managerial lines. This obedience of sorts is presented by the authors in a negative light. Yet, in contrast, Waring appears to support this internalisation through his calls for managerial technologies to be drawn into professional identity. It could be argued, however, that this in itself would, according to Foucault, be a manifestation of the medical professional becoming a tool within a system of governmentality.

In addition to internalisation, one can assume a range of responses to surveillance. For instance, the challenge of standardisation in healthcare suggests that incentive frameworks, such as QOF, are susceptible to gaming. This can be placed within the context of reactions to surveillance, whereby gaming can be seen as a form of rebellion in the face of QOF as a top down government driven monitoring technology. Gaming may reflect a level of disengagement with the framework and a desire to discredit its

usefulness, whereby participating practices work to only the target threshold required by QOF and some even go so far as to distort the output, rather than use the framework as a legitimate means of improving their clinical performance.

Furthermore, Sheaff and colleagues (2004) argue that top-down clinical quality improvement initiatives, such as QOF, have conversely led to a shift away from the autonomous self-regulation of an individual general practitioner towards the establishment of networks as performance monitoring mechanisms. To apply this to general practice, such networks include formerly the Primary Care Trusts, now the Clinical Commissioning Groups (CCGs), NHSE (NHS England), collegiate bodies and the British Medical Association's Local Medical Committees, and it may be that the persistently underperforming practices choose to remain outside of such regulatory influences. It would be of interest to gauge the feeling of low QOF scorers towards the NHSE which will take responsibility for much of Primary Care Trust's former work. No doubt GP-led CCGs add an extra dimension of complexity to this process.

Increased regulatory transparency is likely to result in defensive reactions from clinicians. Drawing on a Foucauldian framework, in their qualitative interview-based study of how doctors, psychotherapists and counsellors react to regulation, McGivern and Fischer (2012) highlight that the greater the unique complexity of the profession and the level of tailored service to the individual patient (i.e. psychotherapy) the more likely it is to resist regulatory transparency. Yet again, to support the dichotomy between person-centred care and top-down surveillance technologies, the authors conclude that this is due to the simplifying and decontextualising impact of the latter.

Moreover, electronic surveillance can breed resistance. Doolin (2002), in his study of the implementation of a medical information management system in a New Zealand hospital, noted that the increased scrutiny and visibility of the management system caused doctors to engage in resistance and counter conduct. One such form of resistance was to undermine the validity of the electronic system, by asserting one's values in the face of this imposed top-down change. QOF, which to an extent produces a yearly public general practice ranking table, opens GPs up to scrutiny and is therefore likely to result in some counter conduct.

Indeed, this could be an explanation for why some practices have underperformed on QOF for a number of years – they chose to rebel against it. As discussed in earlier chapters, QOF has been widely criticised by the GP community as undermining patient-centred values through needless and often dangerous standardisation (e.g. Mangin & Toop, 2007), which can perhaps be viewed as a public rebellion of sorts. Therefore, it would be of interest to explore whether QOF low scorers rationalise their underperformance by citing professional and holistic values as the reason for their disengagement.

So what of the future of QOF as a surveillance technology? Here it is apt to draw on Shoshana Zuboff's seminal 1988 text "In the Age of the Smart Machine: The Future of Work and Power". As early as 1988, Zuboff explored the potential future impact of computerised technologies as an enabler of organisational control. Building on Foucault with her theory of the 'electronic panopticon', Zuboff's work supports the concept of information technologies challenging professional autonomy and seeking to undermine professional power. Her theory appears to echo Waring's notion of

internalisation of management tools as she presents professional groups as bestowing their own meaning upon, and creating a sense of ownership over, the knowledge and information they apply in their day to day practice. Zuboff argues that the future (rather bleak) implications of monitoring technologies are as follows:

1. That which can be automated will be automated
2. That which can be informed will be informed
3. Every digital application that can be used for surveillance and control will be used for surveillance and control.

Zuboff states that ‘information systems that translate, record, and display human behaviour can provide a computer age version of universal transparency that would have exceeded even Bentham’s most outlandish fantasies’. This strongly suggests that the organisational effects of new monitoring technologies and their application within electronic surveillance systems should be a major theme in the Foucauldian analysis of modern healthcare organisations.

Therefore, the electronic panopticon, it could be argued, will only continue to grow as a tool for continued surveillance of the medical profession. Ferlie (2016) argues that there now exists a climate of ‘decentralised centralisation’, whereby the performance of seemingly autonomous providers of health services is repeatedly surveyed through electronically reported indicators. In addition, the policy centre holds the power to carry out visits to and audits of the providers as an additional tool for on the ground surveillance, with regulatory regimes becoming more inspectorial in nature.

The next section of this chapter will summarise the key questions raised by the theoretical review, the answers to which would potentially aid the understanding of persistently low QOF scoring general practices.

3.3 Summary

This summary is a consolidation of the key questions raised by the preceding background chapters and how these will be applied in the context of stating the research aims and methodology of this study.

Against the policy backdrop of New Public Management, the notable constructs within the literature review concerned the tensions amongst clinicians that can be brought about by the top-down implementation of managerially-led quality improvement initiatives. How government surveillance through performance monitoring can undermine professionalism and a sense of values was explored, along with some of the potential limitations of measurable indicator-based performance improvement frameworks in capturing the true essence of quality of care within general practice

Whilst pay for performance incentive frameworks hold some advantages, they may not capture all facets of quality, in particular the qualitative elements of care in general practice. Therefore, it would be appropriate to get under the ‘skin’ of consistently ‘poor-performing’ general practices with the aim of qualitative enquiry being to shed a light on how the practices operate and respond to QOF. Is it that practices are truly poorly performing and QOF captures this appropriately? Or is there more in terms of how they operate beyond the scope of QOF that needs to be understood? Are these practices simply disengaged with the pay for performance framework due to tensions

between professionalism and managerialism? Are the practices' low scores an indication of their perceptions of the shortcomings of the QOF incentive scheme? How do general practices perceive and respond to QOF surveillance?

These reflective questions are somewhat leading of course, as they make a number of assumptions about the policy and social discourses that the low QOF scores of the practices of interest may be a reflection of. However, it is nigh on impossible to carry out research with a complete 'tabula rasa' to begin with and the researcher will always bring their own values and beliefs to the research process, which is recognised by the epistemological standpoint of this thesis - social constructionism. This is discussed in more detail throughout the Methods chapter. This thesis therefore recognises that 'social research can never be entirely objective, itself being conducted within a social and political context' (Tarling, 2006). Indeed, the tensions between professionalism and managerialism, along with Foucauldian notions of electronic surveillance and panopticism appear to be promising theoretical frameworks at this stage of the study.

In order to eliminate bias however, it is important that the researcher's prior understandings are rooted in a sound evaluation of research evidence, as demonstrated by the preceding review of the literature. The research questions of the study however will be phrased in a neutral tone, avoiding assumptions. This allows for a more inductive approach, which will also be described within the Methods chapter of the thesis, to allow a richness of findings to be revealed through the cases studied.

3.4 Statement of Research Questions

The primary research objective constructed from the review of the literature is as follows:

- To gain an understanding of general practices which have achieved low Quality and Outcomes Framework scores over a five-year period.

The secondary research questions are:

- How is QOF perceived by the practice staff?
- How do the participating low scoring general practices respond to a top-down target-driven quality improvement initiative?
- What role does professionalism play in how the practices respond to regulation?
- Why do some general practices continue to underperform on the Quality and Outcomes Framework?
- What do the participating low scoring general practices do in terms of quality of care, beyond the scope of the Quality and Outcomes Framework?

4. METHODS

The methods chapter will begin with a review of the epistemological approaches found within the social sciences and, more specifically, health services research. Next, this will be placed in the context of the subject of the thesis, namely a study of general practices with consistently low QOF scores. Then detail will be provided about the study design and methods, before elaborating on how analysis was carried out, from data collection to theory building. Strengths and limitations of the methods undergo analysis. In this section, ethical factors as well as issues of reflexivity are explored. In keeping with the ethnographic tradition, personal reflections are offered throughout.

A note on the use of personal pronouns:

I have used both the first and third person throughout the thesis. The first person has been used within the Methods section and case studies. The use of the first person is commonplace in ethnographic research. One of the key features of ethnography is that it sees the research process as lived experience (e.g. Kleinman & Kleinman, 1991). Ethnographers often use the first person perspective in their writing to acknowledge their presence as both observer and active participant in their research setting. On the other hand, in order to present a more formal academic stance, the third person has been used in the theoretical chapters. Writing in the third person is more widely accepted academic practice.

The process of ethnography tells the story of the research itself, beginning the case studies at the outset with the arrival of the researcher as a key player in the process. According to Van Maanen (1990), the use of 'I' conveys a phenomenological sensitivity to lived experience. At times, the text used to convey the day-to-day reality

of the practices may feel informal. However, it is hoped that the style of language used may in itself subtly communicate, or even be reflective of, the culture of the practices being studied. It is apt to quote Clifford Geertz (1988) here, a highly influential American cultural anthropologist, who stated that ‘getting themselves into their text...may be as difficult for ethnographers as getting into their culture’.

This suggests that these two elements are deeply connected, with the text through which research findings are expressed, potentially being an expression of the culture of the organisation being studied. However, Geertz was critical of the ethnographer’s contemplative auto ethnographical stance and dismissed it as a ‘pretence’, when it amounts to no more than the insertion of the ‘self’ within the text. To counteract this rather superficial approach to what Chua, High and Lau (2008) coin ‘one-dimensional reflexivity’, I took notes throughout the research process to record my thoughts, feelings and reflections on the research experience, in particular about the role I played in the research process itself. Thus, my use of the first person is more than just simply, to use Chua, High and Lau’s terminology ‘a game of words’. Yet, as a note of caution, I tried to avoid the pitfall of ‘navel-gazing’ and to participate in personal reflection which was both relevant to the research and research-led (Hemmingson, 2008).

It should also be noted that this is in keeping with the social constructionist epistemological standpoint of this thesis. This is a theory of knowledge that explores the way actors construct their understandings of the phenomena and how these constructs form the basis of their assumptions about reality.

4.1 Study Design

This is a longitudinal qualitative organisational study, the aim of which is to formulate case-studies of the low QOF scoring practices to shed light on the thesis' research questions. The methodology is ethnographically-informed, with data gathered through the process of participant observation. The study is intended to be inductive and exploratory, with a social constructionist focus on how meanings surrounding QOF are created, negotiated, sustained and modified (Schwandt, 2003) by general practices with low QOF scores.

With there being a broader element to the concept of quality in general practice beyond the measurable as discussed previously, as well as the complexity of general practices as organisations, a qualitative approach was deemed most appropriate to the exploratory research questions.

The study consists of five free-standing low QOF scoring general practice case studies, with the emergent findings subsequently being brought together to create a data-driven overarching case study of low QOF scorers. The design is iterative, in the sense that the methodological framework evolved by being enhanced with each case study (Yin, 2003). For instance, the interview questions were reformulated to elicit more information on the basis of what worked well in previous interviews.

Additionally, the study design is ethnographically informed, not only through the application of participant observation in the research process as discussed below, but also being accompanied by theoretical ideas concerning the social processes of the general practices studied. Therefore, 'social process is not captured in hypothetical deductions, covariances and degrees of freedom. Instead, understanding social process

involves getting inside the world of those generating it' (Orlikowski & Baroudi, 1991) and thus an awareness of the social constructions of those studied and how the data may be socially constructed by me as the researcher. This is a pragmatic view of knowledge based on how truth is judged in relation to what is already known. This notion of becoming almost an insider of the studied organisation in order to form a rich understanding of it, is rooted in the ethnographic approach, which will be explored later on in this chapter.

First, in order to present a clearer rationale as to why qualitative methodology was employed to study the low QOF scoring practices, one needs to understand the epistemological considerations underpinning both quantitative and qualitative approaches. The next section will explore these concepts in more depth.

4.1.1 The Quantitative/Qualitative Distinction

The division between quantitative and qualitative research is based on the contrasting purpose and thus methods of both approaches. The purpose of quantitative research is the attempt to quantify social phenomena in order to establish the veracity of a theory's generalisability. Simply put, its ultimate goals are to establish causes and make predictions. Quantitative research aims to therefore determine causal explanations through the use of empirical data.

In contrast, the qualitative process of inquiry holds the contextualisation and interpretation of social or human experiences and perspectives at its centre. Qualitative research therefore emphasises interpretation over quantification and is more concerned with the meanings of social phenomena than its quantitative counterpart. Thus,

quantitative and qualitative inquiries raise different questions about the social worlds that they aim to capture.

With divergent purposes, the two processes unsurprisingly apply different approaches and methodologies. Quantitative research is based on testing a hypothesis generated from an existing theory and is therefore seen to be deductive and confirmatory in nature. In contrast, qualitative research uses an inductive approach, whereby hypotheses are generated through the research. In both methods there exists a systematic interaction between theories and data, but in what appear to be opposing directions.

Often, quantitative research collects numerical data in artificial laboratory settings to remove bias by controlling for extraneous variables. Statistical techniques are then applied to the data. Qualitative research is conducted in a natural 'field' setting with the phenomenological aim of exploring constructs (attitudes, behaviours and experiences) through methods such as interviews or focus groups. Its data are usually in the form of transcripts and words, rather than numbers. Naturally, the interest at the centre of this study, namely contributing to an in depth understanding of low QOF scorers, is suited to qualitative enquiry.

The differing roles of the researcher should also be noted in a discussion of differences between the two methodologies. In keeping with the objective approach of quantitative methodology, the role of the researcher is seen as that of a detached and impartial scientist. Objectivity is attained through adherence to established procedures which prevent the researcher from distorting the data. In fact, a basic criterion in research used to evaluate objectivity is whether the findings can be duplicated by using the same set

of tools and procedures. Being objective can thus be defined as seeing the world free from one's personal position in that world.

On the contrary, the view of the qualitative tradition, to which this thesis is aligned, is that the personal context of the researcher cannot be separated from the data. Indeed, there exists a belief within some qualitative research traditions, notably ethnography, in the researcher becoming an insider being the only means of understanding the world view of your subject. However, within this, the researcher should continue to retain an awareness of the subtleties one's own personal socio-cultural contexts and how they may impact on the data gathering and interpretation.

Although, pointing to the subjectivity of the qualitative approach, this awareness of, or reflection on the researcher's own role almost paradoxically is seen as a way of protecting qualitative research findings from claims that they lack validity or credibility. This concept is termed as reflexivity (see Woolgar, 1988) – the researcher reflecting on the role their own prior assumptions play in the development of their research and how the construction of research findings may have been influenced by the adopted methodology and analysis. Although, one might argue, that simply stating one's awareness of subjectivity may not be the same as endeavouring to remove it altogether, the claim made by quantitative research. A key critique of the social constructionist standpoint, rather entertaining in its tautology, is that because social constructionism is itself a social construct (Hammersley, 1992), then it has no more claim to be advanced as an explanation than any other. This self-refuting nature of social constructionism places it firmly on the qualitative end of the qualitative/quantitative spectrum.

The apparent dichotomy that both the purpose and method of these two approaches create, has been the subject of a longstanding debate around which research process might be more ‘scientific’ and therefore favourable. Quantitative methodology is praised for its high external validity and associated ability to make strong generalizable claims, usually due to using a larger sample of participants and ability to control for confounding variables, and as such can make the claim of greater objectivity.

However, some argue that through this, internal validity is sacrificed as empirical data cannot capture the realism and diversity of the social world (e.g. Glaser & Strauss, 1967). Reason and Rowan (1981:15), in reaction to what they term ‘quantophrenia’, state: ‘There is too much measurement going on. Some things which are numerically precise are not true; and some things which are not numerical are true. Orthodox research produces results which are statistically significant but humanly insignificant; in human inquiry it is much better to be deeply interesting than accurately boring’. As seen in the literature review, this lack of human significance may, of course, also be one of the critiques levelled against QOF itself.

The scientific rationalism of quantitative methodology is based upon an ontology which assumes that ‘the world (social or natural) possesses qualities both independent of our ideas and empirically accessible to us’ (Giacomini, 2010). However, this view is challenged by commentators who argue that this positivist approach fails to appreciate context and ‘abstracts away from time as experienced by practitioners’ (Sandberg & Tsoukas, 2011). It is important to note that my own professional background as a healthcare management consultant may bring with it pre-established understandings of primary care processes which can helpfully shed a light on some of the phenomena observed within the practices participating in the research. Yet, on the

other hand, the inter-subjective understandings proposed by interpretivist approaches, whilst identifying socially embedded knowledge in context, can fail to attend to underlying structural mechanisms which impact on social actions (Bourdieu & Wacquant, 1992).

However, qualitative methods are considered to benefit from high internal validity (though some commentators have argued that the concept of validity should not be applied within the qualitative approach, rejecting the realist assumption that there is a reality external to our perception of it (Lincoln & Guba, 1985)), due to their focus on real world phenomena and attention to individual variation by studying a smaller sample more closely and naturalistically. Yet, it is not possible to make strong predictions or make causal conclusions at population level with qualitative methodology, which is what in opposition to Reason's and Rowan's view would imply that it is quantitative research that holds human significance.

It is worth noting, that the nature of input of each practice into the research process may be a reflection of their sense of empowerment or otherwise. The categorisation of being a 'poor-performer' may have an impact on the day-to-day life of the practice. As a social researcher, I had a responsibility to maintain an awareness of this (Tolich & Davidson, 1999).

It is clear from the literature review, that qualitative methodology which allows for the capture of the softer facets of performance which cannot be defined using standardised quantitative data tools, is key to understanding the outlier practices. Health services research has increasingly started to recognise the value of such methodology (e.g. Allen, Black & Clarke, 2001).

There clearly exists a tendency to treat qualitative and quantitative research as being ‘mutually antagonistic’ (Bryman, 1988). However, while there are differences between the two traditions, these may not be as clear cut as the dichotomous categorisation implies. The chasm within the supposed quantitative-qualitative dichotomy has at times grown through political, social, historical and cultural influences. An oft quoted example is that of some voices of the feminist movement, which highlight the gendered nature of research methodology (e.g. Graham, 1983; Reinharz, 1979). The search for an objective world view through the use of statistical data may be seen as masculine in nature. Qualitative methodology in contrast aims for interpretivism and exploration more closely linked to female characteristics.

Thus, to put forward a crude example, the qualitative interview method may be better suited to female participants, whereas numbers may appeal more to the male mind. Currently the debate continues - Mies (2003) for instance speaks of the androcentrism that prevails within research practice. A critique of this standpoint may be that it purports supposed, rather stereotypical, differences between the sexes, and thus becomes a gendered world view in itself.

One may perhaps go as far as to say that the quantitative-qualitative divide is a product of dissenting voices not immune from social context and fashion, rather than of intrinsic irreconcilable differences between the two processes. Either way, it becomes clear that the theoretical concepts and assumptions underlying both schools of thought need to be considered.

The quantitative-qualitative divide is therefore also a divergence of epistemologies – the positivist versus the interpretivist. The key opposing features of the two epistemological approaches are outlined in the table below:

Table 1: Positivism versus Constructivism

Axioms About	Positivist Paradigm (Quantitative)	Interpretivist Paradigm (Qualitative)
<i>The nature of reality</i>	Reality is single, tangible, and fragmentable.	Realities are multiple, constructed, and holistic. Notion of reflexivity/role of researcher.
<i>The relationship of knower to the known</i>	Knower and known are independent, a dualism.	Knower and known are interactive, inseparable.
<i>The possibility of generalisation</i>	Time- and context-free generalisations (nomothetic statements) are possible.	Only time- and context-bound working hypotheses (idiographic statements) are possible.
<i>The possibility of causal linkages</i>	There are real causes, temporally precedent to or simultaneous with their effects.	All entities are in a state of mutual simultaneous shaping, so that it is impossible to distinguish causes from effects.
<i>The role of values</i>	Inquiry is value-free.	Inquiry is value-bound.

While quantitative methods are based on a natural science, positivist model of testing theory, qualitative methods are based on interpretivism and are more focused around generating theories and accounts. Positivists treat the social world as something that is 'out there', external to the social scientist and waiting to be researched. Interpretivists, in the social constructionist epistemological standpoint of this thesis, on the other hand believe that the social world is constructed by social agency and therefore any intervention by a researcher will affect social reality. Herein lies the supposed conflict

between quantitative and qualitative approaches - quantitative approaches traditionally seek to minimise intervention in order to produce valid and reliable statistics, whereas qualitative approaches traditionally treat intervention as something that is necessary, often arguing that participation can lead to a better understanding of a social situation.

Perhaps, the resolution depends upon the ontological and epistemological perspective of the researcher. It may be that some research questions are better suited to a particular methodology, which is specifically the case here, with the research aims being to gain a greater understanding of the qualitative facets of low QOF scoring practices.

4.1.2 Conducting Ethnographically-Informed Research

There are a number of epistemological approaches in the field of health services research and ethnography is a relatively new, but growing method in this discipline (e.g. Allen et al., 2001). When I began drawing up the design of this study, ethnographic methods within the field of health services research were relatively new and few and far between. As part of an immersion within the world of ethnographically-informed research, at the early stages of the PhD, I spent time meeting prominent ethnographic health service researchers at conferences and individually. These meetings reconfirmed my resolve to apply an ethnographically-informed approach to the study of ‘poor-performing’ practices.

I began to understand the methodology as an ideal way to shine light on a phenomenon. These new colleagues I met helped me understand that ethnography as a tool in social research can simultaneously capture a number of facets of a case – the organisational, sociological, political, historical, psychological – to name but a few. I saw this process

of exposing myself to the reflections of others in the field, as the beginning of my initiation into ethnographic healthcare research, helping me to understand that multiple factors intersect to inform the research journey.

To conceptualise this within theory, I learned about what Buchanan and Bryman (2009) refer to as the need to attend to ‘organizational, historical, political, ethical, evidential, and personal factors relevant to an investigation’ and how these influence research. Indeed, Van Maanen (2009) argued that these factors play a clear role at the analysis stage, when uncovering thematic aspects.

Ethnography can be defined as the study and systematic recording of human cultures, customs and understandings. It is not just a methodology, but also a construct about ways of perceiving cultures and societies. The word ethnography itself comes from the Ancient Greek for ‘folk’ and ‘I write’. It is the presentation of recorded data on human societies which has grown in popularity in the field of social science. However, ethnographical research is rooted in anthropology. Traditionally, anthropologists would spend years immersing themselves in the field, usually seeking to understand the cultures of distant tribes and to present those findings within ‘thick description’. Indeed, traditional anthropological texts, such as those of Malinowski, make for fascinating reading, giving a powerful insight into the day to day realities of tribes and disparate cultures. Naturally, the time constraints of a PhD do not allow for such profound immersion in one’s research subjects. Therefore, the methodology of this study can only claim to be ‘ethnographically-informed’. This symbolises that the research process embraces principles of participant observation and the socially-constructed nature of reality, as the most fitting to meeting its aims.

4.1.3 Combining Inductive & Deductive Approaches

This study will use a hybrid of the inductive and deductive approaches. Although potentially a Foucauldian theoretical framework has been established in line with a deductive approach of applying pre-existing categories to data, this will be used loosely. This means that Foucault's is seen as a promising theoretical perspective at this stage, however the applicability of this framework will be evaluated against the data. Therefore a data-driven inductive approach was employed, allowing for new unexpected information to be included in the study.

Thus, the following question will be asked throughout: can the patterns of organisational behaviour that are observed be understood using Foucault's theoretical framework, and furthermore how should the framework be modified in the light of the evidence? Indeed, according to Yanow and Tsoukas (2009), qualitative research rigor is concerned with recognising openings rather than following a predetermined schedule inflexibly. To support this, Langley (1999) calls for an inductive approach, which is nonetheless balanced against early structure. This combination of approaches will also be employed during the analysis phase.

4.2 Recruitment

Recruitment began in the year 2010 and continued alongside fieldwork within already recruited sites until 2012. A previous study (Ashworth et al., 2011) quantitatively identified a cohort of 212 general practices (2.7% of general practices in England) which remained in the lowest decile for total QOF scores in the four years following the introduction of the QOF. This was achieved by obtaining QOF data covering the

four years April 2004 to March 2008 for all general practices in England. These data covered the following domains: chronic disease management; practice organisation; patient experience; additional services; and access. Longitudinal cohorts of poorly performing practices were defined based on their total QOF score over each of the four years for which QOF data are available. More detail of this method can be found in the publication of the study itself which is included in Appendix 11D.

From this cohort of 212 practices, five practices were purposively selected from a number of different geographical locations to ensure that there is some representation of the spread of general practices nationally, as well as of practice type. However, with such a small sample of five representation may not be achievable. This is not necessarily seen as a limitation within the interpretivist tradition, whereby Lincoln & Guba (1985) argue that ‘the naturalist can’t specify the external validity of an enquiry, she can only give a thick description essential to enable someone interested in making transfer to reach a conclusion about whether a transfer can be contemplated as a possibility.’ Furthermore, within this purposive sample, practices were recruited at opportunity in terms of who could be contacted on the ‘phone first and who appeared to show an interest in taking part. Beyond being mindful of geographical location and whether or not the practice was a group practice or a single hander, I tended to work upwards from the lowest QOF scores nationally on the list, which were around the 300 point mark, compared to around 700 out of 1000 at the top of the lowest 10%. The lowest of the low scores may have indicated a real sense of poor performance or perhaps simply an outright rejection of taking part in QOF recording and thus I focused on attempting to recruit these practices first.

At the start of the direct recruitment process, the lead GP or the practice manager was approached by telephone in the first instance. At this point assurances were made that their contributions to the study would be confidential, no identifiable data would be published and findings would not be reported to the PCTs (now disbanded and replaced with a new managerial infrastructure, PCTs were in place at the time of the study). The potential participants were then provided with the information sheet (see Appendix 2). The information sheet was designed to be informative, indicate that the research would be minimally intrusive and to engender trust in the potential participants that their contributions to the study would be kept confidential. Following this, the lead GP was given two weeks or so to consult with their teams if appropriate and decide whether or not to take part. Once the lead GP agreed to include their practice in the study, written consent was sought from them and an information sheet was forwarded to them to be distributed to the practice staff.

Written consent was sought (see Appendix 3) from the practice staff members at the first face to face contact with them, which took place at least two weeks from the staff receiving the information sheet, giving them time to decide whether or not to take part in the research. All practice staff were able to opt out of the observation and/or interview elements of the study.

The lead GP or practice manager was offered a £200 payment made to the practice account for time lost due to participation in the study as a goodwill gesture.

Challenges were foreseen at the recruitment stage. The stigma of being labelled as a poor performing practice is a worry for most GPs. The research process was kept as open and collaborative as possible so as to avoid a QOF inspection feel. Some of those

challenges are presented in the findings of this study, as it was felt that resistance from the practices to recruitment itself was relevant to case construction.

A further challenge was the need to identify a local collaborator at the research site for the purpose of local R&D research approval, requiring permission from the lead practice GP to be named as such, before the form is submitted. This led to a time-delay before agreement for this was given by the GP and the practice visits actually took place. This was appropriately managed by keeping in touch, so that the GP did not lose interest.

4.3 Setting and Participants

Five general practices were chosen from the cohort of low scoring practices.

In line with what is known about the characteristics of poor performing practices, to increase representativeness, the selection of practices was purposive on the basis of practice location, representing the North and South of England, as well as urban and rural settings. Single-handed practices and group practices were recruited to the study. A total of five practices were recruited to increase the potential of transferability of findings to other general practice settings, yet also for the study to be completed within the time constraints of the PhD course.

Within each practice, a purposive sample of staff members representing the range of general practice professions were interviewed (GP, Receptionist, Nurse, Practice Manager etc.), until a data saturation point was reached (i.e. no new information relevant to the study questions emerged from the interviews). Minimal participant information was collected, namely age, sex and job title. See table below for

anonymised information about the study's participating practices and the staff members interviewed from each practice (the order of the practices in the table corresponds with the order of the cases within the findings chapter):

Table 2: Participating Site Information

<i>Practice</i>	<i>Practice Type</i>	<i>Approximate List Size</i>	<i>Time Spent Conducting Fieldwork Within the Practice</i>	<i>Number of Formal Interviews Carried Out</i>	<i>Staff Types Interviewed</i>
1	Single-Hander	1700	6 Days	9	GP Reception Staff Notes Summariser
2	Single-Hander	1200	9 Days	7	GP Reception Staff
3	Single-Hander	1200	10 Days	3	GP Reception Staff
4	Single-Hander	2000	8 Days	5	Reception Staff
5	Group Practice	1000	9 Days	32	Business Partner GPs Reception Staff Nursing Staff Psychotherapist Medical Administrators

There was some discussion between my first supervisor and me as to whether inclusion of a specialist practice would be appropriate to the study, as it is really an outlier amongst outliers. However, it was decided that a practice providing a specialist service

may shed even more light on why QOF may be a limited lens through which to view quality and was therefore included in the sample.

4.4 Research Process

On-site data collection took place in intervals between 2010 and 2013. Interactions with study participants for the purpose of data collection and clarification e.g. by email and member-checking of findings continued to take place throughout the PhD write up until late 2015. It is worth noting that whilst ethnographic approaches are vulnerable to critiques concerning their lack of generalisability, this section of the methods chapter gives a transparent description of the research process that was followed, facilitating the potential of replicability.

4.4.1 Semi-Structured Interviews

The interviews were semi-structured, allowing for the discussion of themes emerging from the literature review, but with questions being exploratory rather than leading in format (see Appendix 4). The ordering of the questions was flexible, so that the schedule could be adapted to the participant and the direction of their responses. This also gave the interviewer the opportunity to explore themes emerging from the interview which were not previously considered.

The participants were interviewed for up to 45 minutes, in a private room within the practice, such as a vacant consulting room.

The interview questions were formulated as the direct result of literature searches in medical, medical sociology, healthcare management and organisational study fields, with a particular focus on factors which are thought to influence performance and engagement with quality improvement initiatives (see Appendix 5). The questions were intentionally open-ended to elicit richness of data, which could potentially be analysed leading to almost a participant-led theoretical framework. The questions were straightforward and practical, rendering them easy to answer. They were designed in such a way that they could be answered by all professional groups within the practice, allowing for a triangulation of responses between the different staff members. The interview questions pertained roughly to the following areas:

- Perceptions of general practice quality
- Organisational characteristics and behaviours of the participants' practice
- Influences on their own and their practice's performance
- Perceptions of QOF.

A key disadvantage of leaving the interview questions rather general and open-ended is of course the breadth of findings they may elicit, outside of the scope of the thesis. However, as the aim of the thesis was to gain a greater understanding of the participating practices through a social constructionist lens, it was decided that this understanding of the meanings that interviewees ascribe to their experiences of QOF can only truly be gained by greater induction and openness. The interview questions allow for this, without pushing a specific predefined agenda.

4.4.1.1 Piloting the Interviews

The interview schedule was piloted with six individuals working in general practice – two GPs, one male, one female; a nurse practitioner; a practice manager; a healthcare assistant/smoking cessation advisor; and a healthcare assistant/receptionist. The interviews lasted between 20-55 minutes. Some of the findings from the pilot phase are presented below.

The pilot interviewees were asked to comment on the interview questions and process, bearing in mind that the actual interviews would be conducted with members of low QOF scoring practices. The feedback of the pilot interview participants has been incorporated into the final interview schedule (see Appendix 4). This was a useful stage in the research development process by helping me to become more confident in and familiar with conducting the interviews.

The following is the feedback provided by the pilot interviewees on the interview schedule and process. I asked the participants to give feedback in light of the research interviews taking place with low QOF scoring practices.

- All pilot interviewees liked the way the interview flowed and felt that it was suitably open ended, with questions acting more as prompts
- The Healthcare Assistant said it was very useful how the questions were adapted according to the flow of the interview, as that had the potential of bringing out more information by being linked to the interviewees agenda

- The Practice Manager and one of the GPs said that it would be helpful if I was more explicit about the first question which asks for a definition of quality. Although I have kept this rather vague in order to elicit as much of the respondent's opinion, in line with the feedback of the Ethics Committee, I have since broken this question down into 'define good and bad quality' (see Appendix 4)
- The Healthcare Assistant/Smoking Cessation Advisor and Practice Manager felt that more personal questions would create a better rapport in the interview and achieve a more open disclosure. Therefore, I have altered questions around incentives to the more interviewee-centred 'what motivates you to perform well?', as well as added questions about their working lives at the practice (see Appendix 4).

As can be seen in Appendix 9, the data from the pilot interview stage were analysed using NVivo qualitative analysis software. This was used as an opportunity to trial the software and discover whether its use would facilitate the analysis of the study data. Although useful in helping to organise large datasets which are inevitable with ethnographically guided research, the programme seemed to surprisingly forge a distance between me and the data. In the actual analysis process, as an emphasis of the ethnographic principles of immersion and observer interaction with data, I preferred to refer directly to interview recordings and transcripts and conduct the analysis manually by repeatedly annotating and highlighting consecutive versions of printed datasets.

However, interviews in themselves may only reveal an element of what a practice is like as an organisation, particularly as the interview process can be influenced by social desirability response bias, whereby the interviewee wishes to come across in a favourable light to the interviewer (Fisher, 1993). Therefore, the additional tools of participant observation and documentary analysis where appropriate, were included to formulate the practice case-studies, in order to facilitate a qualitative ‘triangulation’ of data within the cases.

4.4.2 Participant Observation

The ethnographic tool of participant observation was employed. A distinction can be made between participant and non-participant observation. Although I was unlikely to be taking part in the life of the practice in the same way an employee would, by having a presence in the practice and communicating with practice staff I became a participant observer.

Initially, to gain greater confidence in taking field notes during participant observation, I had the opportunity as a healthcare management consultant to practice this within one of my consultancy client practices with their verbal permission, over two hours. The notes were discarded on the same day. This very brief pilot gave me an insight into how the field note taking process ought to be sensitive to the participants of the study, and how not be perceived as inspectorial. I am able to demonstrate greater sensitivity by taking notes out of sight, and not when openly observing an event, so as not to make the participants feel uncomfortable. Discomfort may naturally lead the participants to

act in ways that they naturally would not and this could potentially confound the findings of my study.

Furthermore, it was important that I regularly explained why I was taking notes, the likely content of those notes, and that any identifying data would not be included in them. This acted as reassurance for the participant, which again enabled them to be relaxed and act more natural around me. My reflections here are guided by Van Maanen's approach, as he maintains even these sorts of almost routine interactions should not be taken at face value. Rather, I should maintain a sensitivity to them throughout the research process. Here, I was approaching the research process with my student ethnographer rather than management consultant hat on.

I observed the day-to-day life of each practice over a minimum of five days. The rationale for this minimum length of time, is that it could allow for a range of practice situations to be observed over a working week, such as a practice meeting or the reception area during clinical sessions. I made field notes throughout.

These observational visits were not always consecutive, depending on what was convenient, as well as emerging data. However, five days really was a minimum, established for those practices which may have been reluctant about being visited for any longer. Rather, it was hoped that sufficient time would be spent to try to understand how participants construct their social worlds in terms of the theoretical framework and its limitations, whilst maintaining an openness to 'uncharted ground' (Rosen, 1991). The time spent on observation would also have to be in keeping with the time constraints of the PhD.

I often ended up contributing to some of the tasks at the GP practice. This meant that I quickly underwent an initiation into the role of participant observer. Contributing to tasks such as welcoming patients, making teas or filing paperwork, meant that I could provide concrete help that reduced others' workloads and provide reciprocity for the many opportunities that were useful to my research. Becoming a participant observer in this way helped me to appraise the practice organisation almost from the vantage point of being its staff member and thus greatly facilitated my immersion in the field.

I endeavoured to take fieldnotes in a sensitive and open manner; however, at times it was more appropriate to suspend immediate concerns with writing to participate more fully in the situation that was being observed (Emerson et al., 1995) and then would complete my notes at the end of the day.

4.4.3 Documents

Emerging data from participant observation and interviews was 'triangulated' by sourcing practice documents, such as policies and guidelines, leaflets and job descriptions. For instance a member of staff mentioned the lack of job role clarity and further evidence for this was sought by looking at job descriptions, if these were in existence. Patient notes were not accessed; however, the methods used to record and submit QOF data were observed. The GP from case study 4 submitted lengthy typewritten accounts of their views of QOF to me, which were included in the analysis for this practice.

4.4.4 Thematic Analysis

Data in the form of field notes, interview transcripts and document content if appropriate, were analysed thematically.

Thematic analysis focuses on categorising, analysing and reporting themes within data. A framework of analysis based on the six-phase model of inductive/deductive hybrid interpretive thematic analysis proposed by Fereday and Muir-Cochrane (2006) was applied, using levels of coding in order to generate overarching themes with subthemes.

The six phases are as follows:

1. Developing the code manual
2. Testing the reliability of the codes
3. Summarising data and identifying initial themes
4. Applying a template of codes and additional coding
5. Connecting the codes and identifying themes
6. Corroborating and legitimating coded themes.

The thematic analysis was conducted from an interpretive, social constructionist standpoint. Orlikowski and Baroudi (1991) state:

‘Interpretive studies assume that people create and associate their own subjective and intersubjective meanings as they interact with the world around them. Interpretive researchers thus attempt to understand phenomena through accessing the meanings participants assign to them.’

Interpretive thematic analysis is suited to the phenomenological aims of this study, namely its concern with increasing understanding of the meaning applied to the concept

of general practice quality and the subjective experiences of key players within the general practice organisation.

Thematic analysis is suited to more data-driven inductive approaches, as well as deductive studies guided by the application of pre-existing frameworks to the data (Fereday & Muir-Cochrane, 2006). However, the interpretive stance suggests that a truly inductive approach, free from the application of pre-existing meanings by the researcher, is not possible. Therefore, prior literature review themes which related to Foucault's notions of surveillance and tensions between clinicians and managerialist frameworks were sought out within the data throughout the analytical process. However, during the phase of data analysis, these were not the only promising theoretical frameworks; complexity theory and Mintzberg were also considered as potential explanatory models. It is only post the analysis phase that Foucault and Managerialism vs. Professionalism were selected to be reviewed in depth in the literature review. Bringing these a priori understandings to data analysis is in keeping with the epistemological standpoint of social construction, whereby our realities are viewed as being shaped by our prior knowledge and experiences.

It is clear, therefore, that a balance between induction and deduction was sought within this study. This brings together the benefits of both approaches, whereby the emergence of new findings about low QOF scoring practices is facilitated, whilst remaining guided by, but not limited to, the theoretical framework. This approach underpins Fereday and Muir-Cochrane's six step approach as described above.

Member checking of emergent findings was carried out by asking the participants to comment on the accuracy of the themes and amalgamating their feedback with the data. Inappropriate generalisation can be identified when the participants of a study refuse

the legitimacy of that generalisation. Therefore, member checking helped to overcome this, whereby participants were asked to clarify some of their reflections noted within the interview transcripts and fieldnotes and to comment on their case studies. This was not done in a systematic manner, as the level of engagement in the research process varied from practice to practice. Often, I sent excerpts of transcripts and field notes for clarifications, along with the case study drafts by email and hoped to get a response. This may have been followed up with a telephone call to the practice and I noted down any feedback I received and incorporated it into the cases. Notably, contact was lost with case study 3; the data from which are arguably the most controversial. Had the GP from this practice been able to comment on the findings, member checking would have been employed in a sensitive manner, restating that confidentiality would be upheld at all times. Therefore, some practices had a more significant ‘voice’ in the analysis phase of the research process than others. However, recognising the uniqueness of the contributions of each case within the research process is one of the strengths of the ethnographically-informed approach.

Emerging themes were discussed in supervision meetings and a small selection of data was checked by the PhD supervisors for blind inter-rater reliability (Boyatzis, 1998).

4.4.5 Documentary Analysis

There are a number of ethnographic questions which can be asked about text to facilitate its analysis. These questions were utilised throughout the analytical process.

1. How are texts written?
2. How are they read?

3. Who writes them?
4. Who reads them?
5. For what purposes?
6. On what occasions?
7. With what outcomes?
8. What is recorded?
9. What is omitted?
10. What is taken for granted?
11. What does the writer seem to take for granted about the reader(s)?
12. What do readers need to know in order to make sense of them?

Hammersely & Atkinson (1983)

This approach was not, however, followed systematically. Usually, these questions were almost subconscious considerations, part of the process of me understanding the extent to which the few practice documents I did look at (e.g. practice policies) could contribute to case construction. I asked myself whether or not the documents somehow reflected the working practices of the study's participants, as well as potentially their understandings of what it means to deliver high quality care. The GP at Practice 4 in particular chose to communicate through the use of documentary evidence their experiences of QOF and it is at this practice that documentary analysis was mostly applied.

It is worth noting, that texts in themselves, as standalone data, are not sufficient to answer the research questions posed by this study. For instance, it cannot be gauged from analysing text alone, how a general practice functions on a day-to-day basis. Additionally, Atkinson & Coffey (2004) state that documents cannot be taken as

concrete evidence of what they report. In this vein, the analysis here viewed texts as social constructions, in line with the interpretivist approach. In most cases, documents were simply used to cross-check or clarify some of the claims expressed during interviews.

4.4.6 Constructing Case Studies

Some commentators have argued that explicitly stating the intent to develop case studies at the outset, before the analysis stage, increases reporting bias (e.g. Feifer et al., 2007). However, from the perspective of this study, the aim to create individual cases served the purpose of highlighting the uniqueness of each practice studied and presenting an in depth illustration of them. The aim of an ethnography is to provide a ‘thick description’ of the phenomena studied, eliciting an immersion-driven richness of themes.

An ethnographically-informed organisational case study can be seen as being ‘predominantly concerned with those social relations coalesced around a subset of goal-oriented activities’ (Rosen, 1991). A case study can be defined as a method of illuminating ‘a set of decisions: why they were taken, how they were implemented, and with what result’ (Schramm, 1971). However, beyond that, the study design aims ‘to uncover and explicate the ways in which people in particular work settings come to understand, account for, take action, and otherwise manage their day-to-day situation’ (Van Maanen, 1979). The study design is therefore not only suited to the aims of building an understanding of low QOF scoring practices as organisations, but also to getting ‘under the skin’ of these practices to elicit themes concerning the research

questions. Gaining an unprecedented rich insight into the uniqueness of cases is often the focal point of ethnographic research. Therefore, the outlier nature of the study's participants was not viewed as confounding factor, rather a focal point, allowing me as the researcher to embed myself in the social life of the practice, whilst adopting a reflexive approach to the field of study.

Conversely, the criteria for ensuring rigor in the formulation of case studies are seen to be largely conflicting within ethnographically-informed organisational research methods. Gibbert & Ruigrok (2010) argue that, in light of this, researchers should take care to explicitly outline the actions they take to construct their case studies. Furthermore, they claim that formulating a description based on a formulaic step-by-step process may mask the reality of the emergence of the case. Thus, being more transparent about the true case study formulation process raises the credibility of the results.

Indeed, the approach to case construction within this study was not always systematic, and rather drew on saliency of themes and concepts related the study's research questions. Furthermore, the process employed an element of deduction, whereby the potential theoretical frameworks suggested from the literature review (e.g. Foucault/Managerialism vs. Professionalism) were to an extent used as a comparative checking mechanism against emerging themes. Whilst this could be criticised for limiting the richness of data to fully reveal itself and drive the study's findings 'bottom up', it can also be argued that case formulation was clearly rooted in pre-existing theoretical evidence. Furthermore, this helped to organise the immense volume of data that this study generated into easier to grasp cases and subsequently typologies.

Data from interview transcripts, field notes and documentary analysis were brought together to build the cases. These different forms of data were analysed together by analysing parallel themes across them. So for instance, themes common to both interviews and fieldnotes would be highlighted on the basis of salience. These themes then comprised the individual cases. Case study construction was also iterative between the cases during the course of the study. Therefore, to an extent, the structure of each new case built on the preceding one. Hence, the presentation and formatting of each of the cases is slightly different, in order to more closely reflect the natural flow research process experienced within the field. Some cases consist mainly of thick description, whilst the data from other cases lent itself better to organising data around themes from the outset. This approach recognises the uniqueness of each case.

This iterative approach recognised the development of learning, built on emerging knowledge and aided the development of the overarching case. The overarching case was constructed from the synthesis of common and salient themes across all the cases studied, to bring together the findings into workable clear overarching themes. It was felt that an overarching case would usefully distil rich findings pertaining to low QOF scorers in a way that would allow the reader to understand the commonalities and differences amongst them through a concise account. It may be questioned whether or not the overarching case study in fact constitutes a ‘case’. However, as Simons (2009) points out, a case in the research sense is difficult to define. Here the definition proposed by Stake (1995), which argues that the utility of the case is to understand ‘activity within important circumstance’, appears to support the creation of the additional case, whereby it was intended that this would shed light on the low scorers’ overall reactions to QOF.

4.4.7 Constructing Typologies

Typologies have a number of strengths and limitations. Firstly, typologies are useful in helping us to understand complex social realities, through the ease of classification. A further key strength is that typologies also allow for a clear comparison between cases and are heuristic devices used to clarify the theoretical dimensions of a specific type (Bailey, 1994). The limitations of this approach include the fact that typologies are often not mutually exclusive or always fully comprehensive. Thus, there may be similarities and differences between cases, and typologies may create pigeon-holing by ignoring significant characteristics of the cases studied. Classifications, once defined, are also usually static, and seldom allow for changeability within cases. Of course, social sciences mostly perceive the social world as dynamic and constantly in flux (e.g. Lerner, 1978). Therefore, typologies are perhaps more useful in helping us to understand cases at a specific point in time. So, it could be argued that typologies are descriptive rather than predictive. Bailey (1994) proposed that typologies are vulnerable to reification, meaning that they will erroneously be treated as ‘real’ empirical entities. However, in order to avoid this problem within this study, the typologies were constructed directly from the findings of this study. The typology is presented in this thesis with the aim of operationalising complex phenomena into usable labels which would help to promote understanding of ‘poor’ QOF performance with quick ease. The typology is designed to be easily usable and to capture facets of the study’s participants with short but salient labels, which would appeal to the imagination of policy-makers and clinicians alike.

In addition, it is worth noting that a number of these issues pertain to the field of social science research as a whole, rather than typologies specifically. The complexities of

understanding social phenomena mean that cases will always be difficult to define fully and comprehensively. This does not of course preclude an attempt to do so as helping us to achieve a depth of knowledge and understanding unavailable prior to undertaking research.

So how were the typologies within this thesis constructed? As one of the few explicitly recorded approaches for developing typologies of social phenomena, the methods of Kluge (2000) and Kelle and Kluge (1999) were loosely followed. The following steps employed in this study were adapted from their methods:

- Development of relevant analysis dimensions
 - Identifying dimensions to group the cases on their similarities
 - The overarching themes were utilised for this purpose
- Grouping the cases and analysing data commonalities across cases
 - Asking whether there is sufficient heterogeneity within and between cases to warrant grouping
 - The cases were grouped in the overarching case study
- Analysis of meaningful relationships and type construction
 - Meaningful relationships were revealed through thematic analysis, resulting in type construction
- Characterisation of constructed types
 - Types are described by means of their unique attributes
 - Appropriate memorable titles were given to the types in order to broadly capture their characteristics. The characterisations were discussed and reviewed further at academic supervision, to reduce the bias of the researcher in type construction.

Notably, Bailey (1973) pointed out that empirical commonalities and relationships between cases must be analysed in order to construct meaningful types of social phenomena. The labels proposed in the typology offered at the end of the findings section offer a useful meaningful glance into the organisational character of the studied practices. These labels are drawn from the salient themes within the cases, but also from an awareness of what makes each case distinctly different from the other, or indeed where the commonalities between cases lie.

4.5 Ethical Considerations

This study gained ethical approval from the Brighton West Research Ethics Committee on 15th March 2010 (REC Reference 10/H1111/15). The Ethics Committee made a number of useful suggestions for developing the study which were utilised, such as endeavouring to approach the GP partner directly in the recruitment process to increase its chances of success.

In addition, local Research Governance permission for each practice locality was obtained. There were some difficulties with the process and, at the time, they were expressed with a British Journal of General Practice opinion piece (see Appendix 11 C).

The principles of informed consent, confidentiality and the right to withdraw were adhered to throughout the study. Written consent was collected from all participants. Participant observation and interviews did not take place until consent to participate has been voiced by the participants. It was not possible to seek written consent from all

who were involved in the situations being observed (e.g. they may have appeared within the scenario for a very brief period of time which was not significant to the research process, e.g. porters collecting samples) and guided by research ethics, I did not include their contributions in the thesis or any resulting publications.

In order to preserve confidentiality and anonymity, no participant identifying details, other than designation within the practice (and age and sex, if relevant and did not allow for identification), are included in the thesis or any resulting publications. Data are stored and presented in an anonymised fashion, using participant codes (e.g. Practice 2 Nurse 1). Due to the stigmatising nature of being a poor QOF performer, the practices included in the study are not identified and any possible identifiers such as list size are presented in a range and others, such as location, kept general. Contributions to the study were not shared between the participants, nor details of other participating practices.

It was in the interest of the study to conduct the fieldwork in an unobtrusive manner, so as to keep the situations observed as natural as possible. Yet, some disruption to the practice's day with the researcher observing, asking questions and conducting interviews was unavoidable. However, this disruption was kept to a minimum, particularly in patient areas, so as not to affect the level of patient care offered. Patient consultations were not observed. Any patient information linked to identifiable patients revealed through the course of the study was not used in the research.

The interview questions have been designed to be as non-leading as possible (see Appendix 4) so as not to cause the interviewee distress. The protocol to be put into place for dealing with misconduct or malpractice coming to light was to raise any issues with the study's first supervisor in the first instance who, as a doctor on the Medical

Register, is bound by the General Medical Council's Code of Conduct. Situations of this nature were to be dealt with on a case-by-case basis, though no such reportable issues became apparent.

As there exists a stigma around being labelled a poor performing practice, as well as a fear of reprisal from regulatory bodies such as former PCTs, to counteract this the research process was kept open and collaborative, so as to make sure it did not have an 'inspection feel' about it. Thus, I explained my activity within the practice to participants regularly and revisited consent. The participants were able to view all field notes if requested and give feedback on findings.

4.6 Reflexivity

Reflexivity was practiced throughout the study, recognising the existence and impact of researcher bias within the research process. Following Van Maanen (1990), these issues contribute to the social context of the study and can therefore directly impact on its delivery. Reflexivity can be defined as an awareness of the researcher's own contribution to the construction of meanings and an acknowledgement of the impossibility of remaining impartial to one's subject matter.

Reflexivity can somewhat be linked to the earlier analysis of combining inductive and deductive approaches. Even at the very inception of the thesis, my interests and values have influenced my choice of research topic and methodology. I have a background in healthcare management consultancy and, at the time of the study's inception, was carrying out a number of projects to help general practices improve their QOF scores. I saw this drive as somewhat devoid of meaning and detached from direct quality

patient care, as GPs and their staff rushed to input data on system in order to increase their QOF scores. It was likely that my personal views here may have elicited similar views from the participants, due to me potentially presenting an empathetic stance to this and them feeling like they can communicate similar perspectives with ease. Nonetheless, I was careful to avoid conveying my own views explicitly. My main professional interests were more qualitative, developing teams, teaching communication skills; I began to resent constantly needing to validate the outputs I was helping my clients to achieve through the numerical.

Therefore, in the spirit of reflexivity, my professional background, along with a Master's degree in Public Management, led me to plan and undertake this study. I did however desire to understand the practices studied without preconceptions where possible and rather be passive and not leading in my approach. This enabled me to alter my world view by gaining a greater understanding of the numerous facets of GP performance and engagement with quality improvement initiatives. Nonetheless, it can be seen that my professional context and experience had an influence on the design and conduct of the research presented in this thesis.

To relate the above reflections to theory, this openness to new understandings has been coined as the 'phenomenological attitude' (Finlay, 2008). Openness is intertwined with reflexivity, but the researcher undergoes an 'iterative struggle' whereby previous assumptions have to be managed against retaining an objective stance, but should also be, according to Finlay, 'exploited as a source of insight'. Therefore, our previous knowledge and learning has a key part to play in carrying out insightful, perceptive and self-aware research.

Reflexivity is also an understanding of the dynamics between the researcher and their subjects. As a researcher, I am likely to have a different set of beliefs to my research participants, therefore, I am unable to achieve complete objectivity in the way I view the studied practices. I have therefore endeavoured to recognise when my own assumptions about the world and social context have played a part in the research process. In particular, I have done this when writing field notes, by noting down my own personal reflections, thoughts and feelings throughout and weaving these into the creation of the case. Ways in which my own personal explicit and implicit perspectives constructed the research interpretation were therefore reflected upon during the course of the study.

I have strived to be reflexive in my approach to participant recruitment, attempting to maintain an awareness of how my previous experience of working professionally with poor performing general practices as a management consultant may have influenced my recruitment approach. My professional background here may have been a facilitator of successful recruitment as I was aware of some poor performing practices tending to have a sense of mistrust towards external institutions. Therefore, my approach to recruitment was based around engendering trust towards me as a PhD student with a transparent research goal, rather than as a management consultant or manager.

Furthermore, reflexivity is an important consideration due to the interpretive stance of this study. Geertz's definition of data (1973) underlines to me the need to be able to reflect, in a social constructionist framework, on the way my values influence the research process: 'what we call our data are really our own constructions of other people's constructions of what they and their compatriots are up to'. Most importantly, according to Orlikowski and Baroudi (1991), 'the interpretive research approach

towards the relationship between theory and practice is that the researcher can never assume a value-neutral stance, and is always implicated in the phenomena being studied'. Therefore, my role in and influence on the research process are reflected on throughout.

It is worth noting therefore, that in line with Orlikowski and Baroudi, the presentation of the findings themselves within the thesis may also be a reflection of my professional background. As an independent management consultant, I often had what I perceived to be the luxury of not being prescribed models and performance management frameworks to use with my clients. Rather, I preferred an inductive approach, where during my initial visits to clients I would allow for a flow of information, which I would often record through note taking, almost in the sense of 'thick' description, which only then I would set about organising into meaningful themes which could help me identify suitable interventions where required. The case studies are presented within the thesis in a similar way, as stories, which I then organise around the emergence of key salient themes.

4.7 Supervision and the Writing Up Process

Supervision sessions were initially held weekly with the first supervisor and gradually developed into less frequent session with both supervisors towards the end of the writing up process. Supervision was primarily used to explore the applicability of potential theoretical frameworks to understanding the case studies. In later months, this moved towards what the study could bring in terms of new knowledge and potentially enhancing pre-existing theory about poor performance and disengagement with quality

improvement initiatives. Having the input of supervisors was invaluable in helping to gain greater understanding of the phenomena studied (e.g. Zhao, 2003).

The writing up process was in itself iterative and data-led. Whilst a literature review was conducted to inform the research questions, as mentioned previously, a number of potential theoretical frameworks were rejected due to their limitations in elucidating the findings. Therefore, a mix of induction and deduction was employed, with the slant of the thesis being tailored after the analysis. During the course of the write up, the research participants were contacted for feedback as part of member checking, and their comments integrated as appropriate.

The course of the PhD itself was staggered. As a result, the research was undertaken in a policy and NHS climate different to that of today, whereby applying ethnographic research to the study of healthcare organisations was relatively unique. However, the write up has endeavoured to align the findings of the study to current research where appropriate, raising questions about the future outlook in today's NHS.

4.8 Context of Health Services Research

The healthcare sector is of course one of huge importance, playing a crucial and necessary role in maintaining the health of the nation and screening for and treating disease. Economically, the healthcare sector is of great scale and scope, with around 9% of UK GDP apportioned to it and rising (World Bank Group, 2011). The NHS is one of the largest employers in the world, employing groups of different professional staff, including doctors, nurses, allied healthcare professionals and non-clinical administrative and managerial staff. The NHS plays a crucial role in sustaining and

promoting the health of the public. McGivern and Fisher (2012) describe the health sector as being of high sociological interest, particularly in the case of being a key site for researchers who are interested in the notion of professionalism, which is of relevance to the themes of the literature review.

Health services research has been defined as *‘the multidisciplinary field of scientific investigation that studies how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviours affect access to health care, the quality and cost of health care, and ultimately our health and well-being. Its research domains are individuals, families, organizations, institutions, communities, and populations.’* (Academy for Health Services Research and Health Policy, 2000).

The research problem of this thesis is therefore inherently aligned with the discipline of health services research. It is hoped that this thesis will contribute to a greater understanding of the characteristics of low QOF scoring general practice organisations and the socio-political context which surrounds them. Potentially, implications which may contribute to more effective implementation of quality care are likely to be put forward.

4.9 Strengths and Limitations of Methodology

To sum up the methods chapter, the strengths and limitations of the proposed methodology will be appraised.

The key limitations of the methodology concern pitfalls of qualitative social research more broadly, namely issues around generalising findings to the broader population.

This constraint will be expanded upon in the discussion section of the thesis, however, it is worth noting that the study did not seek to construct generalisable findings. Instead, its main focus is to reveal unique, non-generalisable, phenomena. Therefore, attempts at generalisability may have undermined the richness of a case.

Furthermore, it has already been explained that critiques are levelled against the subjectivity of the participant observer approach, in that my personal views may lead me to draw biased conclusions. Nonetheless, in the tradition of ethnography and social construction, my personal interaction with the field is viewed as a key facilitator of eliciting richness of data and thick description (Geertz, 1988).

Significantly, the patient voice was omitted from the study. Therefore, patient consultations were not observed and patient perceptions of the practice not taken into account. Naturally, this would have enhanced the findings. However, within the time constraints of a PhD, the inclusion of patient data may have been too broad, shifting the focus away from the key aim of the study of understanding persistently low QOF scorers.

Lastly, the limitation of the process of typology construction paralleled some of the aforementioned shortcomings of typologies more broadly, namely their reductionist nature and overlap of features. Sensitive to Bailey's (1994) claim that 'a classification is no better than the dimensions or variables on which it is based', it was a challenge distilling richness of qualitative practice data into essentially a soundbite. Indeed, there were some similarities between the types, however, they did not outweigh the differences enough to warrant including those practices within one typology. Utilising the overarching themes to create the typologies, facilitated the process of ensuring that

the typologies were firmly rooted within the rich overarching synthesised findings, in order to decrease the problem of reductionism.

Nonetheless, the typology is a powerful time saving device in capturing the dominant features of the practices studied, which are relevant to the main tenets of thesis, namely understanding low QOF scoring practices and their responses to the scheme. It is worth underlining, that the typologies proposed in the thesis are not intended to be static entities, they simply illustrate and seek to define a point in time and do not preclude the possibility of change. Here, the researcher actively seeks avoid the paradox of falling into the same predicament as QOF - imposing a static framework to understand complex phenomena.

Next, the findings of the thesis will be presented as five case studies, with a final overarching case synthesising the findings.

5: FINDINGS

The findings presented here take the form of five case studies and one overarching case study. The presentation of each case reflects the flow of the research process.

5.1. Case Study 1

Recruitment

The longitudinal QOF performance data suggested that this practice was particularly disengaged from QOF. Its scores were some of the lowest in the country overall (circa 300 points), with no significant increase over the six years since QOF's introduction.

The recruitment itself is however relatively straightforward. Unlike with the majority of low scoring practices, I am able to get through by telephone straight away. In fact, despite calling outside of clinic hours advertised on NHS Choices, the single-handed GP picks up the phone. There is some initial resistance from the GP, which is highlighted by the phrase I note down in my recruitment field notes 'you're lucky to have caught me on the 'phone at all' and a slightly suspicious 'how did you identify us?'. However, soon the conversation becomes pleasant and the GP voices their desire to be able to voice their views, which they suggest are negative, by confidential means. The GP agrees to research participation and claims that the process will be 'therapeutic'.

The Practice

The practice is in a quiet well-maintained residential area of a small village, with a patient list size of approximately 1700. The nearest hotel is half an hour away by train.

The end of the road on which the practice is situated flows into wild open countryside. It is the middle of Summer and I feel grateful to be based in such idyll.

The practice premises are neat, purpose-built and around twenty years old, with a designated car park. I arrive and am warmly welcomed by the receptionist, who is aware that I was coming. She says that they were excited about having me at the practice. I briefly wait in the clean waiting room, alongside two patients. The waiting area has unique circular red velvet seating and appears to be well-stocked with tidy, up to date local and national health information. There are young people's Chlamydia screening packs at reception and seasonal 'flu posters, suggesting engagement with current public health initiatives. The practice rooms are clearly signed. I can hear relaxing panpipe music playing in the background. I am then taken to the homely staff room and kitchen area and offered a drink. I immediately notice the smiley staff photos displayed in the staff room. I feel at ease.

I learn that this single-handed practice is staffed by a senior receptionist full-time, two job-share receptionists, a practice nurse two days a week, and a notes summariser three half days a week, who is also a trained phlebotomist. The practice nurse is away at the time of my visit, as is one of the half-time receptionists. The practice nurse is a recent addition to the team, employed by the GP to improve QOF data recording. I attempt to book a telephone interview with the practice nurse post my visit but prior to me going on maternity leave, but this doesn't come to fruition. It is an oversight that I do not pick up on this again post my return from leave and therefore the voice of the practice nurse is not included in the presentation of this case study. There is no practice manager, but the senior receptionist jokes that even though she is referred to as the practice manager

by patients and other agencies, she does not get the pay. A midwife runs clinics fortnightly from the practice. A health visitor runs a clinic from the practice monthly.

The practice has a drugs dispensary in house. The receptionists have all completed dispensing courses. It strikes me how convenient this is for the residents of the village, who would otherwise have to travel to the nearest town for medication. Apparently, a new chain pharmacy was opposed by village residents who wanted their medications to continue to be dispensed at the practice and subsequently planning permission was rejected.

The practice is open five days a week with clinics formally advertised as running 10-11 and 17-18 only, with 10-11 on a Wednesday. However, the day-today reality is quite different. The practice operates an open appointment system with patients starting to show up for appointments from the time the practice opens at 8.30. The GP arrives soon after and begins to see patients. I witness the clinics take place until the last patient is seen. This often takes the GP up to one o'clock or well past seven in the evening. The GP on average sees 15 patients per session. Between clinics, the GP is busy with home visits, phone calls and paperwork. The dispensary is open throughout the day and as are the doors of the practice. Patients may pop in to have informal chats with the receptionists and the GP. Wednesday, however, is strictly a half day, and it offers the team an opportunity to catch up on orders and paperwork. The receptionists time their lunch to the minute and take turns to go for their break between 12 and 13.

The Visit

I visit the practice daily for just over one working week and conduct nine interviews in total, some with the same staff members, all lasting more than 30 minutes in total.

Throughout my time at the practice, I am made to feel welcome and part of the team through small touches from the staff such as being offered tea and biscuits and colleagues approaching me to exchange pleasantries. The staff are engaged and interested in my research. They are keen to talk to me and to share their stories. Despite the GP appearing busy, it is emphasised by the GP each day that I can talk to them about anything and the GP makes time daily for an interview. I do not come across any significant discrepancies between what the team members say to me in the interviews and what I observe in practice. I take this as evidence of a close-knit team.

Throughout my visit, I am offered car lifts and the receptionist asks me to text her when I get back to my hotel to make sure that I am OK. I think my pregnancy compounds their sense of worry and need to make me feel well looked after. The village and surroundings and local people are incredibly friendly and a far cry from my base in London. The GP does give me a lift a few times, and this I find is a good opportunity to elicit views and reflections about QOF and the practice.

On the penultimate day, the GP organises a team dinner as a way of saying ‘goodbye’ to me and to spend the £200 research participation fee. The GP says that it would be unfair if the money wasn’t used for the team as a whole. There is a buzz of excitement about the dinner, before and after. I remember it as a warm, pleasant, but professional experience in the surroundings of the most expensive restaurant near the local area. I get the sense that the team like their boss. It is the restaurant where the practice has its Christmas parties. Everyone dresses up for the occasion and the dinner cements for me a sense of affiliation and closeness with the team.

Case Themes

Theme 1: Patient-Centred Practice Ethos

This theme pertained to the ethos of the practice which was rooted in values of placing the patient at the centre of its operations. I note that on the *‘First day (the) senior receptionist proudly shows me sign in reception stating “top 99% of patient survey scores”’* (FN, pg. 4).

The staff seem oblivious to the existence of QOF as they are *‘surprised about my study’s selection criteria – that their practice in the lowest 10% of “anything” especially as they receive such high patient satisfaction survey results. I am told that the patient survey was given out to everyone in the waiting room.’* (FN, pg. 9). Here the patient-centred ethos appears to not have been undermined by QOF, with the GP stating that they resisted getting their team involved in QOF *‘to protect them from the workload and so that they could focus on our patients’* (GP Interview 1).

This patient-centred ethos continues to be echoed by interview data and the observed reality. I too am becoming drawn into this value-driven delivery of care. For instance, *‘I jot down a potential paper idea – what can we learn from small/single-handed practices? This suggests that I think that this practice has a lot of examples of good working practices, which other surgeries could learn from.’* (FN, pg. 6).

The following is a selection of quotes and field notes which demonstrate the saliency of the theme of the patient-centred ethos within this practice:

‘This is a very good practice. Because the GP is nearby, they can respond to any emergency and are flexible to patient need. Also everybody knows everybody in the community. There is also a longstanding relationship between the GP and patients, which means that the quality of care is good.’ (Receptionist Interview 1)

‘One patient wanted a hook for the dog outside when collecting their prescriptions, so we put a hook outside.’ (GP Interview 3)

‘I think quality is improving with the GP’s age, as most of the patients are like family members now.’ (Summariser Interview 1)

‘the practice is friendly, accommodating and approachable...it is a community hub. It is a well-organised and well-managed practice. I have never seen any chaos or heard any complaints.’ (Summariser Interview 1).

This local community knowledge appears to be of central importance to the delivery of person-centred care. *‘I mention portrait photos hanging in reception area of current GP and his predecessors. These go back three generations of local GPs.’* (FN, pg. 12)

The personal staff stories echo this community oriented the practice ethos. Here is a selection of data excerpts to further support theme 1:

‘GP has lived in the local area for 24 years – 6 years running a practice down the road, then 18 in this purpose built accommodation. GP lives in house next door to the practice.’ (FN, pg. 5)

‘Informal chat with receptionist in common room. Knew other PT receptionist well before starting work at the practice and went to school with the senior receptionist.’

Suggested PT option to GP as felt that FT was too much for her. GP accepted and she is grateful for this. (FN, pg. 20)

'I learn that senior receptionist plays with GP's granddaughter – GP let her make snowmen during work with the child, which she remembers fondly.' (FN, pg. 24)

'Senior receptionist knows all patients, has lived in the village all her life and has worked for the surgery for 19 years, she is really proud of this.' (FN, pg. 6)

Furthermore, the maintenance of person-centred care was at times achieved by resisting top down mandates:

'The priority for the practice is access. We have tried to resist the pressure for appointment systems, as I know patients want open appointments as they have told me time and time again so I promise them I will keep this system for as long as possible' (GP Interview 3)

The following quote sums up the first theme well:

'A practice that is caring is a good practice...we try to do our best in helping people with their problems, rather than go through templates and that sort of thing. Trying to do our best for our patients...putting ourselves in their shoes and asking what we would want as a patient.' (GP Interview 3)

Theme 2: Cohesive Working Practices

There was clear evidence of cohesive effective way of working within the team, along with the team demonstrating high levels of job satisfaction, which the GP recognised

as being instrumental to the successful running of the practice. A climate of support within the team appeared to be an incentive to work well:

‘everybody is trying to help everybody in the team so it is an incentive to work hard.’

(Summariser Interview 1)

Here are some key data excerpts which contributed to the construction of this theme:

‘The smallness of things makes teamwork easier....they say a happy team is a productive team’ (GP Interview 3)

‘GP believes that happy workforce, rather than a driven workforce will work better. Senior receptionist says that day goes quick when you are enjoying yourself’ (FN, pg. 23)

‘I try to be approachable, so if you have a problem come and tell me, so I hope the staff feel that they can approach me’ (GP Interview 3)

‘we enjoy working together and say that we are happy working together.’
(Receptionist Interview 1)

‘Close-knit team, mutual trust’ (FN, pg. 14)

In terms of working practices I note that the *‘practice has some outdated systems but ones which seem to work well for their patient size and small team – e.g. GP collecting boxed notes as a way of knowing his clinic list. If the notes are not collected the receptionists will give the GP a call, understanding that the GP may not be aware that the patient is here’* (FN, pg. 9)

These types of rather over-elaborate modes of working appear to be sustained on mutual trust and instinct, which may also render them not generalisable to other settings. This construct appears to extend to the patients also, who adapt the practice's routines:

'When I ask receptionists if people ever get confused when GP calls 'next patient' they say that patients know system well and just count how many other patients are in front of them.' (FN, pg. 14)

Theme 3: Responses to QOF Surveillance

The theme of responses to QOF surveillance featured highly within this case, due to the GP's numerous reflections on the quality improvement framework within interviews and passing conversations. Whilst the rest of the practice staff were oblivious to QOF's existence, this theme is the product of the single-handed GP's unequivocal contributions to the data. In fact, the GP stated that my visit was a form of therapy for them, as they could offload some of their misgivings about QOF. The practice's responses to surveillance were ones of resistance to the framework and how it was implemented, largely seen as posing a threat to the patient-centred ethos of the practice.

The GP almost felt resentful of the framework and how it was at odds with their professional values. I noted that the *'GP describes how taking part in QOF as against their nature "would like QOF to disappear"'* (FN, pg. 7). This reluctant attitude towards QOF surveillance is further supported by the following interview excerpt: *'If their agendas are different and not about improving things that it is difficult to take*

criticism. The PCT say do this and do that, but if you can't afford the resources to do this....sometimes the demands are conflicting and not complimentary. The 48 hour appointment thing for example...those making the demands are not willing to fund the demands' (GP Interview 3).

Furthermore, QOF surveillance was viewed by the GP in the context of sanctions and the drive to weed out single-handed practices. The '*GP mentions that QOF used as a stick to beat small practices with – taking over patient lists of small practices means bigger budgets for big practices with minimal increase of resources'* (FN, pg. 18)

The GP's response to QOF surveillance is strongly guided by their concerns with the limitations of QOF. For instance, in this field note the '*GP says "QOF does not measure quality, as this is a subjective thing that cannot be measured"*' (FN, pg. 6). Furthermore, the '*GP says one size fits all approach to policy-making does not work as there needs to be variation in practice.'* (FN, pg. 11). In this vein, we discuss '*EMIS and Read codes being inflexible and a flawed system – clinicians are preoccupied with chasing correct codes as it impacts on their income, losing sight of clinical care according to GP.'* (FN, pg. 31)

In addition, the GP stated that QOF '*is a false economy because ten hours spent chasing £10 payment. So we avoided that, but we got into trouble because we were outliers GP.'* (FN, pg. 31) and that '*You lose focus away from what the patient has come to you with. QOF does not add to the care of the patient at all. It is not of clinical importance or of importance to the patient and it misses the nuances of the practice of medicine'* (GP Interview 1).

The GP is aware of the improved organisational infrastructure and new working practices required to achieve high QOF scores: *'You will find that the practices that do well on QOF have organised themselves in such a way that they have high scores, particularly through their use of IT, but you speak to the patients and they cannot get an appointment. So they would do better to organise themselves around what the customer wants and not what the government wants.'* (GP Interview 1). The lack of engagement with QOF was not down to the lack of IT skills within the practice: *'The doctor is really good at the computer, (they are) so clever, but (they do not) like them for some reason, prefers paperwork, so (they are) not that keen on QOF.'* (Receptionist Interview 1).

However, the GP could not continue to resist the scheme in the face of mounting pressure from the PCT, and had employed a practice nurse for improving the practice's QOF performance. I note that *'The practice nurse is a recent addition to the team. The GP explains this as a reaction to having to increase the practice's QOF scores or risk being shut down by the PCT'* (FN, pg. 11). The GP indicates in an interview that this is a reflection of the *'QOF technostructure not being advanced enough, so admin core grows e.g. IT support, someone on the phone. I have made a conscious decision not to have admin structure grow as it has no tangible benefit, financial or clinical. I did not want QOF to encroach on our systems.'* (GP Interview 1).

I note that *'now that there has been a permanent nurse for the past nine months systems have improved according to GP – nurse provides phlebotomy, smears, contraception advice, STI screening, smears, health checks, flu clinics, QOF, may be a reflection of the potential of QOF to improve wider practice systems.'* (FN, pg. 21)

QOF surveillance was very much viewed within the context of a threat to professional autonomy: *'the autonomy has been eroded. So although we are self-employed we are increasingly treated as salaried employees without the benefits of being salaried employees'* (GP Interview 3). Along with the enforcement of an unwelcome top-down mandate: *'there is a culture of diktat over time, as we as professionals are not able to decide what is good for our patients. And the authorities are telling us what to do and how to do it, down to which drug we should give, which is irritating...this is recent and it has gathered pace in a sense.'* (GP Interview 2)

However, in parallel with the resistance to QOF surveillance, the GP continued to uphold regular self-regulation activities. I note that the *'nearest other surgery is half an hour away by train with 5k patients – the two doctors meet up regularly as a support network and to discuss patient cases.'* (FN, pg. 14) and the *'GP sees himself as grass-roots GP. He is an elected member of LMC.'* (FN, pg. 21).

The Goodbye

I am sad to leave at the end of my visit. I enjoyed my week at the practice and I feel invigorated at having been part of such a cohesive and positive team. I also feel like I have learnt a lot, in particular through the conversations I had with the GP. I also note that at the start I felt that the receptionist was quite timid. I get the sense that since our interview and dinner last night that the receptionist has gained more in confidence - this is conveyed by her speaking with a louder, clearer voice, laughing with patients, relating stories and talking to the senior receptionist. I hope that some of this is down to the opportunity that the research has given her to air her views. Leading up to the

end of my visit, I am regularly asked when I am going, to make sure the team gets to say goodbye.

On my last day, the practice team gathers to say goodbye, they mention that they really enjoyed my visit and the GP talks openly to their team about low QOF scores at this point. I am given a card with thoughtful wishes for my impending motherhood and chocolates. I leave feeling fulfilled and I reflect that this personal touch is what characterises the practice ethos.

5.2 Case Study 2

The Practice

A single-handed urban practice, this GP surgery operates from a converted house in an area of high socio-economic deprivation with a large immigrant population. The premises have an adequately sized reception area and two consulting rooms. The list size is approximately 1200. There are three part time receptionists employed by the practice. A well woman nurse clinic is created once there are five female patients needing an appointment with a nurse. The opening hours of the practice are advertised on NHS choices as 9-11 and 16-18 four days a week, and 9-11 on Wednesdays. The practice has a paper-free patient notes policy and is wholly computerised. I visit the practice on nine occasions, over the course of two weeks.

Recruitment

The recruitment process is relatively straightforward. I visit the practice in person initially and leave my details along with an information sheet with the receptionist as the GP is not at the surgery at the time of my visit. I then phone back the next day and ask to speak to the GP. The GP says *'oh you're the nice lady who visited yesterday. Yes please I would welcome the opportunity to have a moan about QOF and just to show you that we are not all bad.'* I then book in to begin the field work the following week and to arrive at 9 a.m. on a Monday when the practice opens.

Findings

The following findings are presented as an ethnographically-informed narrative formed from the summary of key field notes and transcripts of interviews (presented in italics) taken at my visits. The data are linked to emerging themes throughout.

The Start of Fieldwork

I arrive at 9 a.m. when the practice opens. The GP has not arrived yet and there are two patients waiting. I sit in the reception area and the patients grumble that the GP is always late and that one of the patients was once seen at 1130 when they had a 9 a.m. appointment booked. This immediately suggests to me that the quality of care within this practice is not of the highest standard.

Receptionist 1 is at the desk which is placed behind glass and metal bars. There are various new patient information and health promotion leaflets displayed in the waiting area. The 'phone is ringing incessantly and I note that the receptionist remains calm and polite.

The GP phones in to ask the receptionist if I am there and instructs her to show me to the treatment room so that I can work from there. She does so very politely, but says that she is not sure why I am there. I explain the purpose of my research to her. She explains that the GP is late due to being stuck in traffic. She then announces the same to the patients. There are now six in the waiting area.

The treatment room clearly suffers from some wear and tear but appears well stocked with an up to date temperature record for the fridge. There are various policy and procedure folders, including child protection and staff protocols.

The GP arrives at 1040 and comes into the treatment room to begin a discussion with me. The GP is not happy for me to record our conversations, as they are sensitive about their voice, which has been affected by an operation to fix damage sustained through smoking. The doctor agrees to me taking notes throughout. The conversation begins with the following announcement: *'I am adapting to QOF now and our scores are*

increasing you will see. I set up nurse clinics in response to patient demand, but they had high DNA rates and the nurses demand a higher remuneration that the practice can afford. Our disease prevalence levels have also gone down, which is where our QOF suffers.'

The GP gives me open access to the practice's patient data on EMIS, I explain that my research does not involve looking at patient records. The doctor asks again why I am studying his practice, as their QOF scores are *'not that bad and the health authority knows the challenges I face. I am over 60 now and the surgery is all I have left so I am facing the challenge of engaging with QOF, otherwise I'll die.'* This suggests a forced requirement to engage with top down mandates, lest face closure. The GP talks to me for another ten minutes, records the fridge temperature, and then begins to see patients ten minutes after that. I note that the first patient has been waiting for over two hours to be seen. The three telephone lines are manned by just one receptionist and the 'phones appear to be constantly ringing.

The View from Reception

There are three part time receptionists, covering working hours of 830-1900, five days a week. I interview receptionist 1 who has been working at the practice for five years, we are sitting behind reception during the interview. The receptionist describes the appointment booking system. Patients ring in or book in person and are always able to get an appointment within 48 hours. However, the system of five patients needing the well woman clinic before a nurse clinic is booked in, does mean that patients have to sometimes wait for a considerable length of time for smear test, particularly as these need to be timed with the patient being mid menstrual cycle.

The discussion then moves to QOF. The receptionist reports the following:

'The low QOF scores have a lot to do with the GP not knowing. There was also a lot of confusion about how things should be coded and PCT guidance has been notoriously unclear. I now inform the GP of the correct codes to use any time any new guidance comes in. However, the GP is not very good with computers and that was the main problem with QOF that things weren't being inputted or coded adequately on the system. It's not that the GP doesn't do the work. Generally, when I used to see the notes, I used to see that the GP does lots of good stuff during the consultation. We had to persuade the GP to go paperless, as we were scanning things in anyway. The doctor was worried about the computers and where the information was going, that we were being scrutinised in some way. But now we moved to a paperless record a year ago and everything is so much more efficient. I don't think the doctor minds it so much now either, but does need a lot of help with IT still, and that often takes us away from our jobs and we get behind, being called in after most consultations.'

The doctor's concerns here suggest a theme of **Poor Adaptation to Change**, demonstrated by anxieties around a paperless IT led data recording environment and the lack of IT capability to fully embrace change. Similarly, a worry of being under close scrutiny points towards the theme presented within the literature review of **Surveillance as a Threat to Professionalism**, particularly in the form of remote data monitoring, with little sense of 'on the ground' ownership over one's data and how it is then utilised and by whom. Yet, most significantly, the quote above links to previous studies which suggested that a solid organisational infrastructure is the key to QOF's success and this can be encapsulated in the theme of **The Role of Organisational Infrastructure in QOF Performance**. Within Case 2, it appears that a lack of IT

infrastructure and staff resource is a notable barrier in this practice to achieving improved QOF scores.

I note that the receptionist reports a number of times that she really enjoys her job, due to the rapport she has with the patients, most of whom she knows by name. I notice that patients coming in rarely have to give their names. One patient says that they cannot wait any longer to see the GP and request a repeat prescription. I am surprised that they are not annoyed, as I would be, there appears to be a learned helplessness around the GP's apparent poor timekeeping. However, there is a steady stream of patients and doctor appears to be seeing patient swiftly. The receptionist says that last month's 'flu clinics were exceptionally busy and the doctor worked all day with no nurse support.

Each day I arrive to conduct my field work, I am warmly welcomed by the receptionists. I also note that they often start before they are due to come in for work. Often an hour or two earlier. My interview with receptionist 2 in a private consulting room also paints a picture of a satisfied member of staff. She started off as a volunteer, and was then offered a permanent position, in which she remained for the last six years. There was practice manager there at the time, but since they left three years ago, she reports that there is less tangible leadership and liaison with outside agencies. The practice has '*become more insular.*' This suggests a salience of a potential theme of **Poor Adaptation to Change**, whereby changes in staff organisation have led the practice to somewhat cease to progress and engage externally. However, she continues to value the interaction with patients and '*sense of community with the patients and team*' at the practice.

The main challenge she notes is working with patients from many cultural backgrounds and the communication barriers this poses. However, she says that that's why the GP

is good and they spend more time with patients who need it. I ask if this causes the clinic to run late, to which the receptionist responds *'yes, most days. The younger generation has less patience with it overrunning, but our older patients really appreciate it. I don't think it's realistic that every patient's problem will fit into a five/ten minute consultation and the doctor recognises this and won't change their ways.'*

I ask receptionist 2 what it's like working with the GP. She describes the doctor as *'old school, so new policies for instance take ages to implement, even entering information on the system feels like such a drag sometimes, as the doctor is just not that good at computers.'* This suggests a theme of **Poor Adaptation to Change**, whereby the GP appears to struggle to undertake and implement new ways of working. I am told that even the doctor's partner came into the practice last year, due to their concern with low QOF scores. The receptionists had to look through notes and input all the information on system themselves. Receptionist two reports that she is more confident that the doctor is entering more and more of their consultations on system, though they still have to keep checking, and that their QOF scores should improve.

I notice that the GP communicates in an engaged manner with the receptionists and vice versa. I get a sense that this small team play to their strengths and gel well together.

The GP's Perceptions

I have a number of in depth discussion with the GP. Throughout my time at the practice, I feel like I am almost granted the privilege of an audience with the doctor and that they enjoy talking to me, which makes a change from what appears to be working in

isolation day to day. I find the GP eloquent and seemingly dedicated to their work on an intellectual level. The interviews are loose and adaptive and I do away with the interview protocol during our talks. However, I also note down that this is a person coming to the end of their career, fatigued by three decades of working amongst a challenging patient community and by numerous ever-changing government mandates. A summary of interview findings provided mostly in the form of a narrative follows.

We often discuss what the GP views as the erosion of professional values within general practice and medicine more broadly. The GP puts this down to patients using the internet to self-diagnose, as well as a prescriptive approach to general practice due to increased computerisation. However, the GP describes the benefits of the use of IT as the potential for more holistic care of the patient, greater application of meta-analyses as an evidence-base for clinical practice and a gradual doing away with the *'false dichotomy'* between primary and secondary care. Whilst this can be seen as contributing to the theme directly stemming from the theoretical literature review of **Surveillance as a Threat to Professionalism**, the GP does paint a mixed picture. Whereby increased standardisation due to the use of IT systems appears to erode professional values from the GP's perspective, the wider use of IT systems within general practice is seen as having the capacity to drive person-centred care, simultaneously facilitate access to a clinical evidence-base and also improve communication between primary and secondary care. Thus, the same tools which can be utilised for the surveillance of professionals, can also be used to benefit patient care.

The concept of professionalism often features in our discussion. The GP sees the introduction of free markets under Thatcher as having eroded the value of primary care. We discuss vested interests and a money-oriented modern society, but that markets can

lead to improvements in quality in the interest of choice. Professionalism and values are described by the GP as being multi-factorial, in terms of how they are understood and the expectations various stakeholders place on them. QOF demands specificity and thus cannot define value, especially not in generalist medicine.

However, the GP sees QOF as playing an important role in preventative medicine and attaining a universal quality improvement, though quality of care will always remain difficult to measure. According to the GP, QOF needs to be adaptive and as money is the driving force, the values of the GP practice will impact on the level of their engagement with the scheme. *'This comes back to the conscience of the GP'*, says the doctor during one of our interviews, *'medicine was always the best profession for me, but I feel like I am being policed, money is not my motivating factor, but giving back to society flourishes me every day. On top of that, I am not the youngest of people, and my work keeps my brain working.'* This can again be viewed within the context of a theme of **Surveillance as a Threat to Professionalism**.

The findings of this case can therefore be summarised through the following themes:

Theme 1: Surveillance as a Threat to Professionalism

Theme 2: The Role of Organisational Infrastructure in QOF Performance

Theme 3: Poor Adaptation to Change.

5.3 Case Study 3

The Practice

The practice is a single-handed inner city surgery. It is a low QOF-scoring practice studied at the point of closure. With a small patient list size of 1200, the practice is staffed by a single-handed GP above retirement age, who trained abroad, a practice nurse providing two sessions a week, and a reception team of four part-timers. The GP has almost 50 years of medical experience and has been based at this practice for 25 years, with one of the receptionists working at the practice for 12. The patient population is ethnically diverse, often with English not being the patients' first language.

The practice is based in a run-down shopping precinct, within a rough inner London housing estate. It operates from a small shop-front premises, consisting of a waiting area with a reception and two clinical rooms. It conforms to the stereotype of a 'lock up shop' with a metal shutter rolled down, closing off the frontage for much of the day.

The NHS Choices website indicates that the practice is open Monday to Friday for three hours from the late morning, closed for three hours in the middle of the day, then open for a further two hours in the late afternoon. This is a total of 25 hours in which patients can be seen by clinicians during the practice's working week.

Recruitment

Despite best attempts at following protocol on my part, the recruitment process is fairly chaotic, and in itself becomes part of the enquiry. It can be seen throughout the

presentation of this case that the theme of **Organisational Chaos and Poor Performance** features highly within it. Notes are kept during the recruitment, giving an insight into the day-to-day functioning of the practice. The practice at recruitment is still an active NHS GP surgery is difficult to access by 'phone. Nine out of ten attempts during the opening times indicated by the NHS Choices website on three separate days, over a two-week period, meet with an engaged signal; the one time I do get through over the 'phone, I am put on hold for 14 minutes, and so I hang up. I am not calling a bypass number, but the same telephone number patients use to contact their GP practice. The recruitment process at this stage therefore mirrors the limited patient access to the surgery to a large extent. The field notes at this stage act as evidence for my frustration:

'Trying recruitment process yet again! Sense of wasting time, but learning about patients' experiences of trying in vain to book an appointment with their GP'
(Recruitment field note no. 2, pg. 1).

It becomes apparent, that arriving at the practice in person may be a more successful form of getting the team interested in participating in this study. After discussion with the PhD supervisor, it is decided that being a GP, he may have more success in approaching a seemingly elusive colleague. This strategy pays off. It is the middle of the working day, but the practice's shutters are down. However, the single-handed GP is at the practice. Visiting requires a forceful knock on the shutters, then heaving up the shutter yourself before being able to open the front door. After me explaining the purpose of the study, it becomes clear that the GP is interested in taking part. The feedback received from the PhD supervisor about this exchange, is that the GP at the practice considers themselves a victim of the PCT's monitoring of the practice. Even

prior to me visiting the practice, it become apparent that a theme of **Victimhood/Blaming as Response to QOF Surveillance** may be particularly salient to this case. This meeting takes place just before I am due to start maternity leave, and the GP is informed that they will be contacted in a few months.

Practice Visit 1

A few months later, unable to get through over the 'phone to arrange my visit in advance, I visit the practice for the first time with my young baby, in order to confirm the practice's readiness to take part in the study. I find the practice team in a state of panic and disarray – it happens to be the day they are closing their doors to the public. The practice team reports that, after an apparent threat from the PCT, that the practice would be forcibly closed due to their continuously low QOF scores and so the GP instead has chosen to retire. Here are the notes from this visit that were written a few hours later:

'Initially my unexpected visit seems unwelcome. I am left outside the practice for a few minutes, as the receptionist and GP discuss whether or not I should be let in. On entering the practice, I see a small reception, with mismatched furniture, and slightly cluttered with old leaflets and local out of date magazines. The reception area is in a visible state of disarray, with scattered loose paperwork. The staff appear stressed and overworked. Three receptionists explain to me that they are taking turns to make 'phone calls to patients about the closure of the practice. There is a last minute scramble to enter smoking cessation QOF data for patients on the asthma register onto the inpractice system. This seems to me a futile effort, as the practice is closing. The doctor begins to prompt their staff to tell me in her words "how badly they have been treated by the PCT". The staff do not say much, other than nodding in agreement to

the GP's statements "tell her how you've suffered from stress and anxiety because of the way you have been treated by the PCT", "tell her that you 'phone patients all day to get them to come in for reviews, but they just don't want to" etc.' (FN pg. 9).

It is worth noting at this stage, that this is representative of what I felt was the GP's communication style with their staff – almost one of 'putting words in one's mouth'. A later encounter described below 'Interview with practice receptionist', shows that although seemingly the GP asks for their staff to feed back about QOF and PCT monitoring, this is often done through leading or closed statements, such as the ones I noted in my field notes above. The closed statements impose the GP's sense of reality – the practice as the innocent victim of PCT QOF monitoring. This again brings out the powerfully overarching theme of **Victimhood/Blaming as Response to QOF Surveillance**.

A young reception staff member tells me that this has been a very stressful time. I am asked to take a seat, and despite trying to communicate the fact that the purpose of my brief visit was to simply ask for their agreement to taking part in my study before submitting my ethics and R&D applications, I am there for just short of two hours (luckily my baby remains fast asleep!). For the duration of my visit I feel like a counsellor. The conversation is very one way with the GP largely talking at me – off loading the events leading up to the practice being closed. The GP describes PCT representatives as rude and at times aggressive, often with encounters at the practice escalating to shouting. The GP is full of praise for and verbally supportive of their staff and how they have coped with the upheaval. The GP talks about the impact recent events have had on their health, namely raised blood pressure as a result of stress. The

GP is close to tears when discussing their close relationship with their patients – *‘I feel most sorry for the patients, some have been coming to me for 20 years’*.

The GP is adamant that they want to participate in my study and want their story published *‘so that others can know what the PCT has done to me’*. The GP verbally nominates me as the person who will get their story heard. I feel some pressure with such a task being handed to me without discussion. The GP reiterates a number of times that *‘they told me QOF was voluntary, so how can they close me down?’* I am given two non-NHS email addresses, one for the receptionist, and one for the GP. They assure me that they will be in touch, and ask for assurance of the amount of money they would be paid for research participation. The GP also mentions that they have considered going into research as a new career choice and that perhaps I could facilitate this for them. The amount of ideas proposed to me during this meeting feels highly chaotic. This chaos is reflected further in the surroundings, in keeping with an overarching theme of **Organisational Chaos and Poor Performance**:

‘Looking around the practice towards the end of my visit, having conducted infection control audits in the past, I am aware of a number of issues, particularly around the level of clutter in the two small clinical rooms. There is a stack of magazines in the toilet, along with a filing cabinet. I leave the practice feeling rather drained, but at the same time aware of having visited at a key, fascinating moment in the practice’s history. The encounter brings a new dimension to my case studies – what happens when QOF is used as a regulatory tool to close down a practice – the stick rather than the carrot – and how the practice reacts. This is a unique insight into how a team reacts to their organisation breaking down due to external mandate.’ (FN 1 pg. 12).

At this stage, I note down the lack of clarity about R&D permissions. This is discussed at supervision and since the GP is retired and no longer an employee of the PCT, a research protocol amendment is submitted to the Ethics Committee instead. As may become apparent throughout this case study, the research process almost shifts away from an organisational study. Due to the fragmented nature of this particular practice, only standalone elements can be explored, and a picture of how the practice functioned as a whole prior to closure can only be built up from retrospective accounts. Furthermore, the case study is biased towards the responses of the practice's GP who contributed the most data to this case study and who acted as a link to former staff members.

The Shift from Recruitment to Participation

The stage at which recruitment becomes participation is blurred. Despite seemingly opening up to me, for the next four months the GP remains elusive and hard to get in contact with. I send six emails to both the addresses given to me and receive no response. The study supervisor decides to pay the former practice premises a visit. These are the notes taken to record my supervisor's feedback:

'Behind the shutters, a flickering light was seen. There was one young girl unable to speak very much English, seemingly doing some work for the GP. The GP welcomes the supervisor warmly, confirms that they are still keen to take part in the study and would like to go out for dinner – study supervisor, GP and myself at some point. The GP gives the study supervisor telephone contact details and vague details of an

upcoming event that they would like me to attend. There is still a sense of the GP feeling victimised at the hands of the PCT.' (FN 2 pg. 3).

This verbal commitment to the study is in conflict with my lack of ability to contact the GP post this encounter. I leave a number of voicemail messages over the next few weeks, on both the GP's personal mobile and the practice answering machine. Finally, I get a call back consisting of praise for my study, which will bring to light '*the nasty work of the PCT*' (FN 3, pg. 1) and an invitation to the aforementioned event. After trying to gauge some details of the event, I am left with simply the name of the private hospital where this event will take place. I am then sent on a time-consuming journey of trying to locate the event details from this hospital. This lack of clarity around commitment to the study and inability to organise meetings in a straightforward manner, is to an extent quite tiring to me as a researcher. This leads me to reflect on the experiences patients could potentially have had during clinical consultations with a GP who is appears unable to specify clear step by step instructions from the outset. The amount of chaos here is astounding, repeatedly contributing to the important theme of **Organisational Chaos and Poor Performance**, whereby the inability of the GP to present ideas in an organised manner likely impacted detrimentally on the performance of the practice both organisationally and in terms of patient care.

When I finally identify the meeting place and time, it is only on the actual day of the evening lecture that I receive confirmation from the GP by telephone that we will be meeting. There is a lot of concern about whether or not I will be able to find a parking space, which takes up almost 10 minutes of the conversation. Despite understanding the GP's good intention to make me feel looked after, and whilst grateful for the concern, I feel rather stifled and unable to exercise my free will. These feelings

underpin my interactions with the doctor – a sort of exhaustion from the chaos and lack of clarity about commitment to participating, and at the same time the GP almost attempting to exercise control over what I do. These feelings are further compounded by a sense of pathos which grows from the time of the meeting and interview at the evening lecture. This encounter will now be described in the following section. It is at this point that the GP signs a consent form to participate in the study – they are also happy for retrospective data to be included in the research.

Evening Lecture – First Recorded Interview

We meet prior to a lecture at a private hospital, of which the aim appears to be to encourage GPs to refer privately to the hospital's specialists. On entering the hospital itself, I notice that there are security guards everywhere, presumably awaiting the arrival of a VIP patient. I also note that the main lecture guests are very elderly GPs, who discuss their excitement about the free food on offer amongst themselves. The event is almost farcical, in that I wonder if the hard sell put on by the hospital's consultants is actually aimed at the wrong audience. The GP also mentions four times that the free pens given out at these events never seem to run out, and so the GP goes about picking up the free pens off other peoples' chairs. The food is indeed delicious, topped off with an intricate selection of desserts. The lecture room has a clean, slightly regal feel with commissioned art work. I am not surprised that NHS GPs are seduced by this hospital's setting.

The interview begins with a discussion about the how computers are a threat to patient-centred care, by distracting the clinician away from the patient to interacting more with their PC:

'Not everyone who is not good at the computer is not treating their patients well'

'There are two ways to do medicine, one is the communication with the computer, one is the communication with the patient. The older doctors are more trained to communicate with the patient, the computer is a bit behind. The newer doctors have more orientation to the computer, they're computer literate and they're more thinking of the computer than of the patient. (...) Therefore I don't think the QOF is very relevant to the standard of the treatment.'

Here it becomes clear that the GP views high QOF achievement as running counter to patient-centred care. The GP presents themselves as being motivated by patient need and, in the excerpts below, treatment. This contributes to a theme of **Patient-centred Care as Justification of Poor QOF Performance**, whereby the GP uses patient-centred discourses as a smokescreen for what was so clearly visible at the point of closure - a poor performing general practice.

The GP produces a document they had written, hoping to get it published through me, highlighting the key reasons why their practice's QOF points were in the 700s. There are a number of grammatical and spelling errors throughout the document. This production of documents becomes one of the ways of communicating a sense of victimhood at the hands of a PCT which didn't understand the practice's unique circumstances. The reasons for the low QOF scores highlighted by the GP were listed within the document as follows:

- Timing of the QOF
- Practice boundaries
- Change of computer
- Links between our (inpractice system) computer and the hospital laboratory (sic)
- Contact with (inpractice system) head office
- Hybrid of patients
- Poor compliance
- Demands of the PCT
- Cytology and Immunisations
- Returning Medical records to PCT.

The GP presenting themselves as a victim in the face of the PCT's interventions and sanctions again promotes the theme of **Victimhood/Blaming as Response to QOF Surveillance**. It could be argued that this response is perhaps the GP's defence mechanism against admitting the active part they played in the poor performance of their general practice. This ties in to the GP viewing themselves as being at the mercy of the demands of their challenging patient population, and their sense of the apparent lack of PCT understanding of this. The GP's clear construction of the PCT as a menacing unjust force, does somewhat detract from having to face and resolve the chaos of their own clinical and organisational practices, which even to me as an observer does at times appear unsurmountable. And here, and not for the first time, I feel as though the closure imposed upon the practice is the only real solution.

Furthermore, as we wait for the lecture to start, the GP presents themselves as a patient-centred altruist, which is perceived at odds with managerialism: *'I won't be that keen*

on the management. I like to see patients getting better. Treatment is what I am trained for. It's my profession and my motivation. This is what medicine is. Learning medicine is so long and it's a dedication to medicine.' and *'I would say, having done half a century of medicine, that treating patients is the power, it's the dedication.'* It is also apparent that these data lend themselves well to the overarching theme of **Patient-Centred Care as Justification of Poor QOF Performance**, with the GP continuously citing their professional values as their key motivator in care delivery. Delivery which was so visibly below par.

In addition the GP clearly views high QOF achievement as the result of data manipulation:

'Those who achieve high scores on QOF, I think this is more to do with the data entry, so manipulating the data, I don't think colleagues are able to achieve any more than 800. You see they employ data summarisers and they move the figures too. And there is another thing, they take the patient out, the one who is not complying. Sorry you have to join another GP. If you are an honest worker I don't think you should be achieving more than 850. 850 is honest, the rest is data manipulation.'

The interview is stops as more and more lecture guests arrive and the speakers themselves start arriving.

These potential barriers to achieving high QOF scores listed by the GP in the document I have been given are not surprising in light of the literature review, and are often cited by GP media to highlight the limitations of QOF's one size fits all approach, not allowing for variations in practices in disadvantaged areas for instance. However, it is worth noting that two practices closest in distance to the case study practice and within

a very similar catchment area, are not on the consistent low QOF scorers list used to identify the study's potential participants. It could be argued, therefore, that this practice's underperformance was linked to factors other than the external ones cited.

The GP gives also me some information about their private life; indeed we begin to talk almost as friends. They have never married or had children, and live in a small bedsit, presently with no hot water or heating. We are meeting at the end of Winter. These snippets of information are delivered in a factual way, seemingly not with the aim of inspiring pathos. However, I cannot help but feel worried to some extent about the GP's lack of a support network. I also reflect about how the GP's team stayed rather loyal to the practice, and I wonder if this sense of almost feeling sorry for the GP that they promote by describing their rather difficult circumstance, is what contributes to this loyalty. This is further compounded by the GP presenting themselves as a victim – I wonder at this stage if this victimhood has become an adaptive mechanism leading to secondary gain – the way in which the GP has navigated their way through their working life.

Another Time-Lapse – Concern for GP

Despite leaving telephone messages to meet up with the GP for follow-up interviews, I get nowhere. I begin to be concerned for the GP, particularly in light of them seemingly being on their own. The study supervisor, also concerned, decides to visit the practice premises on his way to a meeting. Although he does not find the doctor present at the practice, he speaks to the shopkeeper next door. The shopkeeper also mentions being concerned for the doctor, and agrees to get in touch when the doctor is

next in at the practice. When the shopkeeper rings us to say that the GP has returned after a couple of weeks away, I make my way down to the practice premises.

Practice Visit 2 – Second Recorded Interview

I take the opportunity to conduct the second interview with the GP. The practice now has a Word processed sign attached with blu tack to the outside window with the words ‘no longer an NHS practice, private appointments offered’. The juxtaposition of private healthcare provision with the backdrop of the practice’s setting and even the poor quality of this sign is almost farcical and again contributes strongly to the theme of **Organisational Chaos and Poor Performance.**

Throughout this visit, despite saying ‘no’ to tea, I am served a cup of tea and feel obliged to drink it. I am also repeatedly offered biscuits, despite turning them down. This sounds rather ungrateful, but the overwhelming feeling is not one of warm hospitality, but rather of being controlled. The interview itself centres on the PCT visit which led to the practice closing its doors and the GP retiring. The GP questions the ethics surrounding the methods the PCT used in getting the GP to conform to their mandate:

‘it was the actual investigation meeting, not the pre-investigation meeting like they said, so that was a bit of harassment (...) this is absolutely ethically, legally wrong (..) and they wanted to read the notes....actually if you ask me too much I might start crying...how can you come and read the notes. So the medical defence person who was there, the legal representative, said we’ve got to anonymise the notes before you read them...it is an illegal situation to demand to read the notes...you wouldn’t want your

notes to be read by a panel of three people...and then I got rather upset and the LMC person said, look they are harassing small practices anyway...if that's the case then they are going to close me down anyway and if you don't resign through the LMC, we will report you to the GMC and get you struck off. This is bullying or blackmail.'

I ask whether there was a particular reason for this intervention and the response appears to be one of futile resistance in light of inevitable closure:

'It was all QOF...but when we gave them the reasons (for QOF scores) they didn't believe us. I thought that if they went through notes that would give them a reason to complain and take me to the GMC, and the LMC said that that would be more hassle for you, so you should retire. When I said I would retire, they said put the resignation in today by 5 o'clock, so I put my resignation in, but I won't resign until the financial year finishes. OK they said, but then we will come and monitor you until the financial year finishes. And I said OK then come monitor me.'

I ask the GP if it would be OK to interview some of their former staff members. The GP suggests two former receptionists and is insistent that they are interviewed at the practice premises with the GP present. The GP telephones the former receptionists and gives me their contact details with their permission, as well as booking one interview there and then.

Despite the GP being very keen to meet with us for dinner, I am unable to pin down the details of when and where to meet. I find this frustrating, and in the vein of previous encounters, the study supervisor and I do not know until the last minute, whether the dinner will go ahead.

Social Dinner

The dinner takes place between the GP, myself and the study supervisor. It is a very pleasant evening, and the GP puts tremendous effort into making us feel at home, and choosing meals off the menu on our behalf. I take just a few key field-notes. Much of the conversation reiterates what was already discussed in previous interviews.

We discuss the beginnings of the GP's career. It turns out that for 2 years, the GP not only saw patients in general practice, but also worked on-call shifts 7 nights a week. These are colloquially known as the 'red-eye' shifts in the GP community. Then for a further 7 years, this continued for 5 nights a week to supplement their GP income. I raise the obvious question about when the GP actually slept. Their working day consisted of going to morning surgery straight after the night shift, and then sleeping in the afternoon before evening surgery – '*you could sleep at work*' I am told. Naturally, the study supervisor and I are shocked at this exhausting working routine – one that would not be allowed today under the European Working Time Directive, because of concerns about the standards of patient care and risk to the patient.

At one stage in the evening, a slightly inebriated party strike up a conversation with us. On learning that the GP has practiced for almost half a century, they cheer and clap. They also take turns to hug and congratulate the GP. It strikes me that it is these kinds of privileges which come with the social standing of a doctor that the GP thrived on throughout their career. This public reception is seemingly at odds with the following revelation:

I: 'Why did you become a GP?'

GP: In those days being a GP was the easy option. You wrote prescriptions and did nothing else.'

Late into the evening, as we are getting ready to go home, the GP produces a further 6 page document that they would like published about their experiences of being monitored by the PCT. The GP insists on reading this document out loud to us. The GP seems oblivious to our social signals around being ready to go home. On the other hand, I have a sense of loyalty to listen to the GP's story, who is clearly in need of a receptive audience. When the GP asks us to take turns to read out the document on their behalf (which is a rather tedious and laborious task to be asked to undertake during dinner in a restaurant), it appears that listening to their words being read out by someone else, acts almost as a therapeutic exercise, with the GP reflecting intently on their story. The story is heartfelt and is written from the first person and elaborates on some of the challenges the GP has faced in light of the PCT inspectorial regime, which is presented as not being sensitive to the demands of the day to day life of an inner city GP poses, particularly in terms of the diverse and transient practice population.

This is just one of the occasions during which the GP emphasises not wanting their data to be anonymised for the purpose of my study – rather they want their story to be fully attributable in the hope that it can reveal the extent of their suffering at the hands of the PCT. This leaves me in a predicament, whereby I have developed a sense of pathos for the GP and a desire to protect them, and I am aware that any attributable data may be harmful to their professional standing, let alone their pending tribunal case against the PCT. The study supervisor voices this latter concern at the dinner, and the GP appears to take this on board.

When we finally leave the restaurant, the GP asks me to accompany them in the cab back to their practice premises. The GP will stay there overnight, due to having no heating at their home. They want me to help them bring down the shutters at the premises, so that they are safe overnight. I get a real sense of the vulnerability of the GP and a desire to protect them, especially considering the trust put in me at that moment.

Practice Visit 3 – Interview with Former Receptionist

When I ‘phone up the receptionist to remind her of our meeting at the GP’s premises, she asks if the GP will be present. I answer yes, and the receptionist then says that there are things she doesn’t agree with the GP with and feels concerned that she might not be able to say them openly. We come to an arrangement, whereby if the receptionist feels she hasn’t been able to speak openly, I will follow her up with a ‘phone call after the interview.

When I arrive at the practice to conduct the interview the shutters are up and the receptionist is present. She asked the shopkeeper for the keys to get into the practice as the GP is late. In light of the receptionist’s concerns about the GP being present for the interview, we begin before the GP arrives. Whilst interviewing the receptionist, the strength of the ethnographic method becomes apparent. From the perspective of the former receptionist, many of the shortcomings in the way the practice operated are highlighted, again clearly contributing to a significant theme of **Organisational Chaos and Poor Performance**.

The receptionist, who joined the practice after being ‘head hunted’ by the practice’s GP, after the practice she had worked for as a receptionist for 20 years had been shut down by the PCT, begins to tell me her story. I have kept the interview transcript here in its entirety, as it provides a particularly illuminating normative voice to the findings of the case so far. The interview data clearly points to the key theme of **Organisational Chaos and Poor Performance** throughout.

‘Initially I started working four hours a week, but ended with having to show most of them how to put Read codes on, to put the summarisation on – these were the things that weren’t being done. They were working hard, but weren’t getting nowhere, because what they were asked to do (by the PCT) weren’t getting done. That’s why their targets were low and the doctor never understood that. I mean there was only one person who could do prescriptions, I mean you can’t have that in a surgery, you’ve got to have a backup. Because if you come in here on a Monday and that person is ill, you’ve got to wait for the doctor to do it.

I think the doctor basically tried to run it herself, thinking they were doing good, but basically not understanding that this is not running right. The PCT picked up on it. They were tough, but the doctor couldn’t understand what was happening to a large extent. I mean we had one poor receptionist phoning up the same people asking “do you smoke?” I said they are going to get annoyed as you are phoning up the same people every day asking the same thing. It’s not going to change the number, once it’s on it’s on. In QOF only one thing counts regardless of whether you put it on once or twenty times. No one had shown them.

I: Do you think this was a failing of the doctor’s knowledge or the PCT not offering enough support?

I think it was a bit of both. They should have been sent for training. As far as the doctor was aware, as long as they were being polite to patients that was enough, but it's not.

I: How did it feel coming here to work?

(Sigh) I didn't even know if I would stay at the beginning, it was a culture shock, 'cause I thought "how haven't they been closed?", cause they didn't have a clue, nor could the nurse understand.

I: Do you think it's a case of not embracing change?

Yes. Don't get me wrong the doctor was fantastic with the patients – they'd have the patient in there for an hour, but that ain't how it runs on the National Health, 'cause you've got all the other patients sitting here getting worked up.

In recognition of the theme of **Patient-Centred Care as Justification of Poor QOF Performance**, I ask the following, which reveals a clear lack of patient-centred care in practice:

I: So was the doctor all about being patient-centred and building relationships? Did the nurse say anything about the level of clinical care?

It wasn't good 'cause they used the same room and if the doctor was in there, the nurse couldn't be in there. And where we kept things up to date (in previous practice), the speculums, the imms – the nurse couldn't find any smears or the imms has run out or they was out of date. So things weren't kept ticking over.

Reception was all about answering the 'phone, getting the notes out, asking the patient to go in – that was it.

I: Quite old school?

The patients got what they wanted...they were quite difficult...I used to say that the patient don't tell you what to do, you tell the patient...a cold isn't an emergency...there was no boundaries...they'd come and scream and shout at you.

And the doctor is terrible with time-keeping...like they might not get there until a few hours in.'

Illustrative of this, at this point the doctor arrives (half an hour late). The discussion shifts towards the receptionist trying to persuade the GP to let go of the tribunal case.

R: 'The government had said that they wanted all single-handed practices to go so you either had to double up with someone or you went and they made sure that you went.

GP: They should have been honest and phased them out instead.

R: They got rid of all the older ones first, because that way you can say "we're not closing them down, it's retirement".

GP: Did you tell her about the day they came? They said it was pre-investigation and it was investigation.

R: It was bad, because they were supposed to have told the doctor why they were coming, but they didn't and wanted to start that day...it was intimidating...they were looking for stupid things'.

Throughout the interview the doctor keeps interrupting. The GP mentions that the PCT used to intentionally calculate the targets lower in order to close the practice down and that the practice's reception staff often had to correct PCT representatives. The GP is

becoming increasingly passionate in sharing their views, which yet again tie in with the theme of **Victimhood/Blaming as Response to QOF Surveillance**:

R: 'I would even drop the tribunal case. They would make sure they win.'

GP: You may be right, they may win, but it's a point for me to raise.

R: But it's a point for you to have a bloody stroke over.

GP: But then if I don't go to the tribunal, I'll still be angry.'

At this point the GP leaves to make food for us.

R: 'The GP just won't listen, 'cause they are just not going to win their case. There were genuine reasons for the PCT's action, I'm not saying in the way they did it, but actual patient care, so anyone who hasn't been in for five or six years call them in and if they've left the country then take them off the list. But it's a "catch 22" 'cause then your payments go down, but if you get your QOF points, you get your money back.'

R: (challenging population) so it became an excuse, but other doctors nearby used to hit their targets.

R: The GP didn't have a good team – they sent one member of staff to Read code meetings, but she didn't bring anything back...one of you had to be there totally doing the figures and we didn't have the space. You couldn't concentrate as there'd be patients banging on the window if they saw your back turned.

R: The GP was scared of patients. And the doctor is not 100% themselves, you can see that and that was the way the doctor was when they were working.'

At this point I spot a mouse climbing the shelves in the old reception area.

R: 'It's 'cause they don't get rid of anything'.

The GP returns. Despite the receptionist saying that she is not hungry and me saying that I do not want another drink, we are served food and poured drinks. I mention the mouse, the GP says that they have not had the heart to sort this out, and then it is revealed that the GP owns another house nearby, where they wanted to transfer the paperwork from the practice premises, but the builders working on that house ran away with the money *'that's why I am stuck here'*.

Indeed, the sense of victimhood underpins much of the data gathered during the fieldwork with this practice. The practice's low QOF scores are justified by the GP on the basis of external factors such as problems intrinsic to QOF itself and the PCT's inability to understand the practice's unique position in terms of their challenging patient population. Indeed, I do not recall at any point the GP conceptualising any changes which could have been made to the practice's ways of working in order to attain higher QOF scores as potential improvements. There is also no apparent reflection about how systems or clinical consultations within the practice can be improved to raise the standard of patient care. *'So these are outside factors, nothing to do with the level of patient care'* (GP, Interview 1). The interview with the former receptionist, however, reveals a GP seriously struggling to adapt to the changes brought about by QOF surveillance, presenting continued, but futile, resistance in the face of the new QOF regime. The GP becomes increasingly preoccupied with their battle against the PCT.

I am presently in the process of booking an interview with another receptionist. The GP is insisting I conduct the interview with them present at the practice's former premises, citing the receptionist's fragility as a result of the PCT's actions. I am however trying to set up a one-to-one meeting with the receptionist, so that they can

speaking freely about the practice. This interview does not take place as I am unable to make contact after three failed attempts.

Case Themes

The findings of this case can therefore be summarised through the following themes:

Theme 1: Victimhood/Blaming as Response to QOF Surveillance

Theme 2: Patient-Centred Care as Justification of Poor QOF Performance

Theme 3: Organisational Chaos and Poor Performance.

5.4 Case Study 4

The Practice

The practice is a single-handed urban practice based in a run-down converted house on a residential road in an area of low-socio economic status, high unemployment rates and a high non-English-speaking immigrant population. The list size is about 2000, with around 500 of those being investigated as 'ghost' patients at the time of my visits. The premises are cramped, with a small reception area, in need of internal decoration. The patients in the reception area are separated from the receptionists by toughened glass and metal bars. The receptionists' desk is surrounded by paper patient notes, strewn with piles of documentation, notices from the PCT on display, along with hand-written post it notes. The GP consulting room is downstairs next to the reception desk, separated by a thin stud wall, which does not offer sufficient privacy, as the consultations can often be heard in the reception area and vice versa. Up a steep carpeted staircase, there are three consulting rooms, two of which are out of use and locked with a heavy duty padlock, and one is used for the healthcare assistant clinic. The dated WC has no toilet seat or hot water.

The practice team is small, consisting of the lead GP and two receptionists employed full time, one of which is also the healthcare assistant and stop smoking advisor for the practice. A nurse clinic, provided by a visiting nurse, takes place fortnightly. Of particular interest in this practice, is the lack of involvement of the GP in the research process, who remains elusive throughout and, despite my efforts, I am unable to conduct an interview with them.

The practice is open for two one and a half hour long clinics five days a week, with emergencies and home visits taking place after each clinic.

The Recruitment

The recruitment of this practice to the project is particularly challenging. I am able to access the practice through a former senior nurse colleague, who had previously conducted work for the practice to improve their cervical screening rates. In the local area, this senior nurse is seen as one of the few ‘outsiders’ that the GP trusts. The GP is not outwardly involved in the recruitment process and I liaise with the receptionist/HCA throughout, who agrees to me conducting my research. At my preliminary visits, the GP, whose understanding of the English language appears poor, appears confused about the purpose of my visit, but agrees on the basis of me being sent by my former colleague. Although I am explicit about my reasons for the visit and present the GP with the consent form and information sheet, only a loose understanding of why I am there remains throughout my time at the practice and continues to centre around the notion of my former colleague simply having sent me. My 8 visits in total, over the course of three months, are always agreed in advance with the receptionist/HCA and not the GP.

Findings

The following results are presented as an ethnographically-informed narrative formed from the summary of key field notes and transcripts of interviews (presented in italics) taken at my visits.

On the first day I begin gathering data at the practice, I am informed by the receptionists that they had undergone a recent QOF inspection visit, of which they are anxiously awaiting the results. This is the first visit in the last three years, and there is a sense that the visit may have been the result of their poor QOF scores. The inspector is described as ‘unfriendly’ and ‘disengaged’, having reportedly sat upstairs looking at patient notes. The receptionists state that they think this is a way the PCT will cut their income. They do not trust QMAS, as they can see patients on their cancer register for example, but the coding used is not being picked up. They had previously asked the PCT how to code diseases and were told to contact their system manager, but are unaware who that is.

Receptionist/HCA states: *‘We think we are doing it right, and are really trying, and the next thing you know we get told off, and don’t get our money and it’s really frustrating with all the work we’re putting in’.*

I am seated in the reception area and warmly welcomed. My visits often consist of friendly conversation about children and holidays. However, despite this, I get a sense of how industrious the receptionists are. They also work very well together as a team and have been doing so for over ten years. For instance, when one receptionist is speaking to a patient for an extended period of time, I observe the second pick up the phone five times in ten minutes with enthusiasm. Both of the receptionists appear to know the patients phoning in and visiting the practice very well.

I note that the receptionists have a large workload. One is not only a receptionist, but also a trained interpreter who often gets called into the consultations, the QOF lead, smoking cessation advisor and HCA (receptionist 1). Her workload has grown since the nurse clinic was reduced from one a week to one fortnightly, due to an apparent

lack of demand. Though receptionist 2 states *'ha it was only because the GP didn't want to cough up the cash.'* Receptionist 2 has been with the practice for 27 years.

I note the loyalty to the practice in terms of length of service and ask *'why have you worked here for so long? The doctor must be nice to work for.'* At this point both of the receptionists roll their eyes and say that it is much more to do with the convenience and the practice being local to them. They also say that they would *'feel bad for leaving the patients with the doctor, we keep things ticking over at least and translate if needs be.'* Both receptionists report how they like to get to know their patients, particularly seeing them have children. The patient group is reported to be stable, not transient.

I am informed that there had previously been a partner at the practice, who left a few years ago for the new health centre down the road. I ask if the parting of ways was amicable. The receptionists say that this is never mentioned, as if the other doctor never worked here. This contributes to a theme of **Organisational Disengagement**, where potential organisational challenges are not discussed openly and almost 'swept under the carpet'.

The receptionists discuss the heaviness of their workload repeatedly. Currently, the PCT is undertaking a list cleansing exercise, whereby the receptionists are having to prepare 500 sets of notes of patients who hadn't seen the GP in the preceding nine months to be submitted for checking. This is proving challenging with the other day-to-day demands of the practice. I am also shown the pile of solicitors requests for patient information, some going back a five months, which are described as a struggle to deal with.

The main barrier to coping with workload is reported to be the GP calling in at least one receptionist into almost every appointment, mainly to help with the computer and the printing of prescription scripts. I observe this to be the case. I am shocked that the GP uses a bicycle horn to call in the receptionists. I note this to be demeaning and disrespectful.

I ask what types of issues the GP has with IT. Receptionist 1 reports that the GP does not like change and when advised how to enter QOF data on system the GP *'just doesn't listen to me, it's so annoying, I have told the GP so many times what to do, I give up now and just do it myself'*. Another example given to illustrate the GP not liking change is that the receptionists have often suggested the upstairs rooms are rented out for extra income, but this is not welcomed by the GP, who *'likes being a single-hander and doesn't like anyone interfering apparently'*.

Receptionist 2 says that they often have to manage patients who keep returning to see the GP at reception. I ask if this is to do with the rapport and trust the patients have built up towards the GP. The receptionist answers by saying *'well they often go to A&E to seek a second opinion after the GP has seen them.'* I am slightly perturbed when an example is given of a mother coming in five times to see the GP in five weeks worried about her child. The GP is reported by the receptionists as telling the mother that if she comes back again, they will have to treat her head. This further contributes to the theme of **Organisational Disengagement**, in the sense of the GP seemingly failing to engage with the most basic service that his practice is meant to provide – clinical care to its patients.

Receptionist 1 states that she is considering of studying medicine as she has built up so much knowledge and *'could do a better job'* (than the GP). This suggest a theme of

Staff Resentment that perhaps the GP is viewed by receptionist 1 as not having the skillset required to be rewarded with a position of professional power. I do note down that this receptionist often gives patients clinical advice over the phone, regarding their symptoms and medication. This is not the GP's advice read out over the phone, but her own advice. With my very limited medical knowledge, I am aware that some of the advice is somewhat dubious. For instance, she refers for blood tests without acting on the advice of the GP and tells patients over the 'phone to attend A&E instead of booking an emergency appointment with the GP. The receptionist often talks to the patients over the phone in her native language, which removes any transparency from the conversation. On the other hand, the four occasions I witness the receptionists going into the doctor's room to clarify the advice to give to a patient, I describe as 'hard work' due to the language barrier and communication issues between them and the GP. Some of the exchanges consist of raised voices and a sense of tension and competing agendas, it is unclear what those agendas are as I am unable to understand the doctor's voice whilst hearing it from the reception area.

At a later visit two weeks into the fieldwork, I observe receptionist 2 trying to get through some of the solicitors' requests. I ask about the list cleansing exercise, and only patients with names beginning with 'A' have been completed. There is also a bowel screening campaign taking place, with letters being sent to patients reminding them to return their kits. The 'phone seems to ring incessantly. Furthermore, receptionist 1 is working on an audit exercise for next year's QOF. The report from the PCT inspection visit has not yet been returned as the inspector is now off on long term sick leave.

Receptionist 1 is also completing an audit requested by the medicines management team, looking at Ensure prescribing levels. The receptionist questions what she

describes as the GP's overprescribing of the supplement drink. These numerous audits and data collation exercises appear to place a large burden on the receptionists in terms of their limited resources of time and capacity to care them all out simultaneously and in a timely fashion. Thus, this can be conceptualised within an overarching theme of **The Burden of Performance Capture**, whereby excessive demands for performance information capture becoming laborious and stressful, particularly when a practice lacks the organisational infrastructure to undertake them efficiently.

The doctor calls in receptionist 1 with the bicycle horn to interpret during a consultation. When the horn sounds, both receptionists roll their eyes, unsurprisingly fitting in with the overarching theme of **Staff Resentment** at this bizarre practice. I can hear every patient consultation clearly when sitting at reception, as well as the exchanges between receptionist 1 and the GP, which I describe in my field notes as 'shouty'. The second time a receptionist is called in, she comes out the room stating *'I don't know what the GP is talking about, they don't realise I have all this to do.'* I note that there appears to be a power struggle between the GP and receptionist 1 and a clear theme of **Staff Resentment** caused in part for a lack of recognition of the industry with which they undertake their seemingly huge workloads

Both receptionists check after each one of the doctor's consultations if QOF data have been inputted. I often hear *'yet again he hasn't done what I told him to do'* being uttered. I do spot that there are lots of yellow QOF reminder boxes popping up on the screen any time patient records are brought up at reception, in keeping with the theme of **The Burden of Performance Capture** within an under-resourced and highly pressurised general practice reception.

I note that there are rarely more than two patients waiting in the reception area, the doctor sees a steady stream of patients. The receptionists print prescription scripts for patients at the end of a consultation as the GP is reported to be unable to use the printer. The 'phone is answered efficiently and no call is left to ring out. A large amount of the 'phone traffic is created by the booking system, whereby patients have to ring in on the day they want to be seen to book their appointment. A considerable amount of patients are asked to 'phone back the next day if they cannot be accommodated as an 'emergency'. I write 'emergency' in inverted commas, as I see the receptionists using this label simply to fit in as many patients as possible into the limited clinic time available and I question how many of those patients have emergency presentations, but rather have been phoning for a number of days unable to get an appointment.

I record that there is a pleasant buzz around the reception area and a sense of community. Receptionist 2 states *'this is what I love about working here, getting to know the patients, providing them with good customer service, how they come in to ask how my grandchildren are, I think I'd really miss that if I ever left. We are a little family here.'* This interview excerpt does counteract the theme of **Staff Resentment**, whereby the interactions of the receptionists with the patients are constructed by them as being a highly rewarding and motivating part of their work.

The doctor often stops seeing patients at 1030 in the morning to deal with paperwork. At around 11 the doctor leaves without uttering a word to the front desk to carry out home visits. Receptionist 2 says *'I remember when the clinic used to run until 13.30, now the doctor finishes two hours early and still complains. The GP only sees the patients, we do everything else here.'* This seeming lack of interest from the GP in the inner workings of the practice, suggests a lack of engagement with the running of the

practice and a systems-wide approach to clinical effectiveness. This can be captured within a theme of **Organisational Disengagement**. This theme is further supported by receptionist 1 also mentioning that she spoke to the GP asking for an asthma and COPD nurse, which was *'desperately needed'* to achieve better QOF scores. *'The GP as usual did nothing towards this, always leaves things until the last minute, then blames me when we don't get the points. Makes me so angry.'* Again the theme of **Staff Resentment** features highly here and appears to be fuelled by the tensions between the GP and receptionist 1.

At my last day of fieldwork, I make my fourth and final direct attempt at asking the GP for an interview. The GP comes into the reception area and I say 'hello'. I ask the GP if we could take ten minutes today so that I can ask them about their opinions of QOF. The GP says that they are very busy today being on their own. There hasn't been a day I have recorded when them being the sole clinician this hasn't been the case! I am advised to *'speak to the girls'*. Then the GP says that they will speak to my former senior nurse former colleague about this. I emphasise again that my research is separate for the nurse's work at the practice. The GP says we shall book it in for another day. I say that this is my last day as my (now second in the course of this thesis!) baby is due any time now. The GP says let's see how today goes. The GP slips out of the surgery without anyone noticing at the end of his session. I therefore do not get the chance to ever directly interview the GP during the course of the fieldwork at the practice. This notable absence of the GP voice contributes further to a sense of their **Organisational Disengagement** from the practice's operations and any external input, such as in the form of research in this case.

The findings of this case can therefore be summarised through the following themes:

Theme 1: Organisational Disengagement

Theme 2: The Burden of Performance Capture

Theme 3: Staff Resentment.

5.5 Case Study 5

The Practice

This is a specialist group practice in a suburban area of large city, with a patient list size of approximately 1000, operating from two purpose built sites, specifically for patients with substance misuse issues and typically dual diagnosis and employing around 25 staff members. During the fieldwork at the practice I conduct over 30 formal interviews.

The Recruitment Process

The recruitment process is straightforward, this is due to the practice being keen to demonstrate the quality of care it provides outside the remit of QOF. I speak to the Business Partner during the recruitment process who immediately explains to me that the practice doesn't achieve high QOF scores due to the chaotic nature of their practice population, rendering chronic disease management and treatment adherence particularly difficult. The Business Partner mentions that standard practices would normally exception report patients of this nature, however they form the practice's entire population.

Day 1

I arrive to the practice on day 1 and am warmly greeted at reception. The ladies at reception have been informed of my arrival and the purpose of my visit. I begin the day with a meeting with the Practice Manager, who is also the Business Partner in the Practice. Again, I am welcomed openly and handed an organised weekly timetable. The

Business Partner moves the slot of the monthly QOF Practice Meeting so that I can attend during my time with the team. The Business Partner messages one of the receptionists to do so through the practice intranet. There is an immediate response from the receptionist of agreement. The timetable handed to me includes a series of interviews with key members of staff over the week of my visit, as well as the opportunity to join various meetings and observe areas of the two Practice sites, and I feel grateful that effort has been put into the organisation, allowing me to make the most of my visit. This sense of a well-managed arrival suggests that managerial features are implemented into the day-to-day running of the practice and the theme of **Internalised Management Discourses** is one that features highly throughout this case.

At the end of the day, I note down how well-organised and thought out the preparation has been for my visit. A part of me asks whether this is controlling as almost a PR exercise, however, the initial meeting reveals that the Business Partner is genuinely interested in my research, and has a rather pastoral/mentoring approach to students. I am given ample opportunity to talk about my work. The Business Partner also expresses *'I am proud of this Practice and what we have achieved, especially when we deal with such a challenging population and this is a great opportunity to show off, but also get somebody else's opinion about our performance'*. I note that there seems to be a clear level of transparency in how the practice operates and a level of respect towards me as a healthcare professional equal is expressed both through body language and the desire to get me on board with the practice's vision. It feels as if Business Partner is really saying, 'we may be low QOF scorers, but this is not a stigma, we are keen to show you how enthusiastic we are about achieving excellent standards for our patients'.

The Business Partner begins by giving me an overview of the team meetings, which she organises. There is a training session every Thursday morning, often delivered by outside speakers. There are management meetings for the partners which take place once a month in the evenings, again supporting the salience of the theme **Internalised Management Discourses**. There is group supervision for both clinical and non-clinical staff once a month with an experienced psychotherapist. Based on staff feedback, the session was opened up to non-clinical staff six months ago. Individual psychotherapeutic supervision has been provided to the staff since the practice opened over ten years ago. Every week, there is also a clinical meeting, where patient cases are discussed in a team. Outside healthcare professionals, involved in the patients' care, are invited to these meetings. Having worked in the field of mental health in the past, I note down the parallels here with multi-disciplinary working in mental health services and how the primary care practice recreated those models. When I raise this with the Business Partner, the Business Partner says *'to an extent, and a number of our specialist nurses have a mental health background, however, we tend to review our meetings and activities regularly based on staff feedback and what works best for our patients'*. This feedback, along with general feedback about the running of the practice, is gathered through anonymised forms, at meetings, informally and at appraisals. There is a comments box for patients at reception.

At this first meeting, we then briefly discuss the patient population. Around 75% of patients are male. Initially, when the practice first opened the majority of patients were aged 25-35, but this has since shifted as they have a relatively stable patient population due to prescribing methadone. The practice, alongside the PCT, has designed QOF 2, which is almost ready to be implemented- a quality monitoring framework, which is

designed to run alongside QOF and fit the needs of their patient population more closely. They had another version of QOF 2 previously, which was designed to reward certain aspects of setting up the practice, when it was first opening. Again, it becomes clear to me as researcher the extent to which the theme of **Internalised Management Discourses** is so closely illustrative of this practice.

After this discussion, I am then shown around the building, given various door codes so I can move around freely, introduced to staff and shown fire exits. Again, the whole morning feels very organised and I feel welcomed. Some of the staff voice worries that they won't know the answers to the questions I ask. There is a sense of power discrepancy in this statement, and seeing me as an authority figure. I try to reassure the staff that the questions are rather general about how the practice functions and nothing too personal. I jot down a number of times the words '*welcoming*', '*warm*' and '*open*'.

The Business Partner then finds the counselling room, which is empty, in order to proceed with our interview. I note down that I find the Business Partner deeply passionate about her job and insightful. Indeed, it is a rarity for a general practice to have a business partner within it. The title itself appears to be taken from commercial public sector language and supports the theme of **Internalised Management Discourses**, which, according to the literature review, are firmly rooted within New Public Management – the introduction of private sector principles into the public sector.

Some of the key excerpts from my interview with the Business Partner suggest a well-supported practice team motivated by a patient-centred ethos, underpinned through sound management practices:

'I love my job. I really see myself as being able to make a difference to the lives of these patients. Whilst, I don't directly treat them, I try to provide an oversight to the processes within the practice. I am constantly trying to make things better and easier to that we can deliver a service that really benefits our patients.'

'QOF is just one small element of all the work that we do here. Yes, we are unlikely to ever achieve top QOF scores, but when QOF came out we saw it as an ideal way to prompt us to attend to the patients' physical health, when that tended to get side-lined by mental health problems and addiction. Rightly so of course, but nonetheless QOF has really helped us to maintain an organised approach to chronic disease review for instance.'

'We are used to recording data and filling forms for our patients. In fact, QOF is actually not as labour intensive as some of the bureaucratic things we have to do. That's why clinicians here has nominated admin time and we have admin staff that get through a hell of a lot of work to keep things running smoothly.'

'I want my team to above all feel supported by one another. I don't like a hierarchical way of working, I want the partners here to be approachable. At the end of the day each one of our roles has its own challenges, particularly due to the type of practice this is. And that's why we have supervision too, to make sure that we are not carrying a burden when we don't have to.' (BM Int. 1).

Post the interview, I go down to the reception area, where I am greeted by friendly receptionists who are interested in my research and where I am from and so on. I don't sense any suspicion or defensiveness, rather a genuine interest. One of the Specialist Addiction Nurses pops down to say hello, and informs me that they operate an

appointments system, however, will see patients outside of a specific time slot, as long as they turn up on the day of their appointment. They always have one clinician seeing walk-ins and this is to build trust and increase engagement. I say that I will sit in the patient waiting area, which is met with cries of *'are you sure?'* from the receptionists several times and *'wouldn't you rather sit away in the reception area?'* Then I am wished *'good luck'!*

The waiting area is peaceful with only five patients coming and going within half an hour. It is a large area with a pop radio channel being played in the background. There is a range of leaflets displayed, including posters about health, mental health, drugs and alcohol. There is also a poster advertising an allotment owned by the practice asking for patient volunteers. There is also information about the service user involvement group at the practice (I note the mental health service jargon of 'service user', rather than the GP language of 'patient participation'). The group holds various activities, including paint-balling, a basic English course, peer-mentoring course, drugs awareness etc. The vision statement of the group is clearly displayed and reads:

'to help change and support ourselves and others, through building confidence, and to make better services relating to drugs, alcohol and health.'

The suggestions box which the Business Partner referred to at our meeting earlier, is clearly displayed in the reception area. I get a sense that large efforts are made to include the patient voice in the organisation of the practice.

There are three receptionists on duty, who give an impression of well-coordinated industry, interspersed with light gossip and laughter. There is a children's play area and four consulting rooms off the seating area.

The appointments are displayed on a large screen in the waiting area, alongside information messages such as ‘do not consume alcohol in the waiting area’, although two cans of lager are clearly visible on the leaflet table. Another message displays details of how to access education and employment support services. A patient comes in to show his new-born daughter to the receptionists, who respond with coos and enthusiastic cries of congratulations. I note that there is a clear sense of community here for what is a relatively large practice.

Ongoing Fieldwork Findings

I begin the day with interviewing the Medical Administrator of the practice. Once I finish recording, she says to me *‘I would like you to know that I had a really bad time in my previous workplaces and coming here really saved me.’* This suggests that the practice has an intrinsic element of support between the staff and indicates the thematic salience of **Supportive Working Practices**.

My subsequent interview with the Specialist Nurse, and also Partner at the practice, confirms this. The Nurse says *‘everyone works so well here. There is great management, so roles are clear, but they are also adapted if needed, to make sure that we support one another.’* (Specialist Nurse Int. 1).

Furthermore, there is a strong element of clinical supervision within the practice, taken very much for the field of mental health services. Indeed, the Nurse explains that: *‘We have one to one clinical supervision once a month and on tap so there’s always help available, along with numerous professional meetings, so we know that there is always peer support and professional discussion available to us, particularly when we are*

dealing with quite unique cases. Having the input of others, along with clinical colleagues from other disciplines, we can have a more rounded approach and make sure the patient gets the best care possible.' (Specialist Nurse Int. 1).

In line with this, I had noted previously that there is a scheme within the practice allowing receptionists to sit in patient consultations to get an idea of the interventions presently provided by the practice for specific patient groups. The receptionists tell me that this is also so they get a better idea of the workload and working practices of the clinicians. Similarly, clinicians and partners have also undertaken reception tasks and shadowing to build their awareness of work being conducted 'front of house'. These empathy and understanding building shadowing practices also extend to wider services within the patient pathway. For example, I am told that a couple of GPs and receptionists have shadowed the pharmacist at the local rehabilitation centre. It is reported that this particular pharmacist is very much liked by the patients for giving them leeway if they are ever late for their methadone dose, instead of requesting they go through the frustration of having to be issued with another prescription. I note down that not only does the practice build empathy and role awareness through shadowing to build greater team cohesiveness, but also extends this understanding to other services along the patient pathway. There is a particular appreciation of patient-centred care within the practice, at all levels of the organisation.

A number of further successful and patient-centric working practices are revealed in the course of the interview: *'We hold longer consultations here, the sheer complexity of the patients that we treat here and the amount of information we have to gather and record, of which QOF is just a small part, can't be squeezed into a five minute consultation.'* (Specialist Nurse Int. 1).

The theme of effective, yet patient centred care continues throughout the interview: *'We do have a young practice population so acute problems do tend to be managed in house. So we do at times practice a more acute medicine here. Our patients also trust us and often do not want to go to hospital. We sometimes do tend to see patients with their families. So we will see our patients' children, who will be seen within half an hour, unlike in normal general practice when you are usually left waiting if acutely ill, that's if you can even get an appointment and then you end up with a referral to A&E anyway. We do our best to manage our patients here to reduce their frustration and also prevent them from using A&E unnecessarily.'* (Specialist Nurse Int. 1).

Within this person-centred approach, there appears to be a strong element of empathy and localism, along with a dedication to one's work:

'For myself it's that I am a local person, this is my town and this practice is not far from where I was born and brought up. I can see myself in many people that come here and by being ten fifteen years older than them I am aware that these problems weren't just around and I feel a lot of empathy towards these people as I feel that that could have been me had I been born just a few years later. And people can change, no one is a lost cause.' (Specialist Nurse Int. 1).

And:

'The partnership was offered to me by (another GP partner) when they were planning to open the practice. A need was recognised within the PCT for specialist support for this population, so I was approached on the basis of my mental health nursing experience. And as someone with a lot of passion for this work, there was no way I was going to turn it down.' (Specialist Nurse Int. 1).

An excerpt from an interview carried out with one of the GP partners echoes this need-focused approach closely:

'I have always been drawn to working with vulnerable populations, have always found this so much more rewarding than typical general practice. Had I not had the opportunity to establish a practice such as this, I may have well considered working as a prison GP or another role related to mental health perhaps. It's just so rewarding knowing that you have the resources to offer help to those who have otherwise been let down throughout their lives.' (GP 2 Int. 3).

During the course of the fieldwork at the practice, I tried to get a sense of whether bureaucracy had encroached on their ability to deliver person-centred care. However, this did not appear to be the case. Rather, QOF was seen as a welcome addition to the range of tools used within the practice to improve the health of their patients, and participants seemed to embrace management discourses keenly:

'I have ten sessions a week of which one is dedicated to meetings, two to admin and the rest to clinical work. My admin sessions do tend to be completely dominated by QOF [laughs] and LES' and DES'. But I do get the need for these things. I do have an interest in the new consortia and getting involved with PCT initiatives and hope to get involved in commissioning as I have an interest in strategic stuff. It is outside my comfort zone, so I am interested in what makes the cogs turn and the politics behind it. At the moment it is all the usual suspects putting themselves forward for these positions and I am hoping that I won't be overshadowed by them and will have a chance to get involved.' (Specialist Nurse Int. 2).

Furthermore, an adjunct to QOF to run in parallel with it, called QOF 2, has been developed with the PCT as a recognition that QOF did not best fit the needs of the practice's population. *'QOF 2 is a way to make sure that the targets we are working towards are tailored closely to our patients. Otherwise, it would be short-sighted to focus our energies and resources in areas that didn't directly benefit our patients'* (Business Partner Int. 3) and *'I think QOF2 was created because the PCT had listened to us and realised that we would be struggling to get points on the actual QOF.'* (Specialist Nurse Int. 2). Here the creation of QOF 2 supports theme of **Strong Patient-Centred Ethos**, whereby QOF is adapted, tailored and utilised within the framework of person-centredness and recognising the unique needs of the practice's patient population.

After the interview, I continue to observe the reception area, whilst helping out with some electronic filing. The Clinical Support Worker is developing posters for an alcohol awareness week and is asking for the opinion of the receptionists. There is a sense of community with eggs from a colleague's farm being sold at reception.

Later on, whilst I sit in the staff room on my lunchbreak, the staff are very friendly and each one to enter the room engages in small talk with me. There also doesn't appear to be any power asymmetry between the administrative staff and GP partner who enters the staff room and washes their tea mug and makes jokes with the rest of the team. I note that I would have trouble identifying any hierarchies within the team had I not been aware of their job titles. This is clearly in keeping with the theme of **Supportive Working Practices** and an ethos of team cohesion and egalitarianism.

The practice operates from two sites, to allow ease of access for patients. Patients can visit either site. The second site is smaller, offers fewer clinical sessions based on

demand (though this is flexible) and staff are rotated to man reception and work sessions there.

I note that staff are very helpful and things get done quickly. For instance, just after I interviewed the Clinical Support Worker, they called the IT Officer to log me onto the PC whilst I was waiting for my next interview. The IT Officer appeared straightaway and resolved the issue immediately. The staff are also aware of when their interviews are and take a proactive engaged approach and phone reception to locate me before the interview is about to take place.

The staff intranet holds all the clinical and organisational policies and protocols for the practice which are regularly reviewed and updated. All staff are aware of this, have access to it, and refer to regularly and actively using this information for guidance. I have a look at some of these policies and am impressed at how comprehensive, easy to read and accessible they are. I note that much time and effort is put into maintaining this database of guidance, of which the Business Partner is in charge. However, the staff mention that the policies are regularly circulated and they too have an input into their content and presentation. They say that they are at times faced with unique incidents, for instance ones consisting of violence and aggression from patients, and procedures are regularly updated drawing from the learning from those incidents, which is usually discussed formally at staff meetings, to enable them to deal with similar situations in the future in line with practice policy. This adaptive approach is highlighted by a number of excerpts from interviews with GP partners:

'We try to do our best to work around the patients. This helps them engage with us. We have to understand that these patients will often be late, or turn up without an

appointment. That's why we often adapt our day to fit our patients and make sure that they get seen and treated.' (GP 1 Int. 2).

The theme of **Supportive Working Practices** comes across strongly here:

'Yes, we all work quite well together. I think that over the years we have tried so hard to engender a sense of understanding around how crucial each cog in the wheel is. I couldn't do my job without the receptionists, the nurses. Goodness know I don't have the management mind needed to do the work our (Business Partner) does.' (GP 1 Int. 3)

'We really value everyone's input here, there are some great ideas and rarely do they come from the doctors. We can be quite fixed in our ways! That's why the multidisciplinary meetings and various training we do give us a clearer view of what happens to the patient along the various pathways, and means we don't work in isolation, which wouldn't be beneficial to the patient or the practice for that matter.' (GP 2 Int. 3).

I attend a QOF and SLA (Service Level Agreement) meeting which is held at the practice every four weeks for two hours. Having attended similar meetings in the past which are usually highly bureaucratic and dry, I am struck by how skilfully patient-centred this meeting is. Low and high QOF scores in various domains are discussed in the context of each patient. Possible explanations for the scores are given and interventions constructed from interactive multidisciplinary team feedback. The motivation behind this meeting appears to be solely the patient's wellbeing rather than the achievement of high QOF scores. The staff seem highly engaged in the meeting, and all staff roles are invited to attend and are represented, alongside external clinicians

involved in the patient's care, for instance dieticians and social workers. This again contributes to the overarching theme of **Strong Patient-Centred Ethos**.

The Goodbye

The team gather at reception at the end of my visit to say 'goodbye', with representation from junior and senior administrative and clinical staff, again suggesting a team cohesiveness with a horizontal task ethos. In the continued supportive spirit of the practice, I am given a card and chocolates, along with a gift for my yet to be born baby. At the end of the practice visit, I make the following note to myself: *'going home feeling inspired by the cohesiveness and spirit of the team and the good work they do.'*

The findings of this case can therefore be summarised through the following themes:

Theme 1: Internalised Management Discourses

Theme 2: Strong Patient-Centred Ethos

Theme 3: Supportive Working Practices.

5.6 The Overarching Case

The overarching themes of the study are presented here. Data have been synthesised and brought together under the umbrellas of the most salient themes common all participating practices. These are as follows:

5.6.1 Theme 1: Perceptions of QOF

As participants were asked directly about their perceptions of QOF, it is not surprising that this is one of the overarching themes of the study. However, what was interesting is that the perceptions of QOF and engagement with the framework varied across the practices. Case 5 saw QOF as a valuable addition to their pre-existing continuous quality improvement methodology. Case 2 had a relatively balanced view, though did perceive it to undermine notions of professional autonomy, particularly in the context of a challenging patient group. Case 3 had a clear dislike, verging on detestation, of the framework and perceived it to be a tool of surveillance, used punitively. This was unsurprising, as the practice was undergoing closure due to poor performance. The GP views within case 4 were not directly recorded, however, the input of the receptionists within the practice implied an engagement with it at the administrative end and a clear lack of participation with the framework clinically. Case 1 perceived QOF very much in the context of unwelcome top down monitoring and the increase of managerialisation resulting from it as a threat to clinical decision-making and autonomy, threatening values of patient-centeredness. Therefore, only one of the practices perceived QOF to be a useful tool, with the others rejecting the framework for its lack of alignment with

their professional values. Overwhelmingly, the practices saw QOF as a limited lens through which to monitor and improve service quality.

5.6.2 Theme 2: Role of Values

Indeed, all practices studied, regularly voiced their alignment with professional values as drivers of their person-centred approach to care, at all layers of the organisation. The notable absence of the GP within Case 4 did not preclude the receptionists in this practice from expressing their support for patient-centeredness within their work. However, whilst these values were ever present in discourses around the limitations of QOF, the threat of managerialism, and general practice care quality, in three out of the four cases they did not translate into reality. Rather, values were used as rationale for both engaging (Case 5) and not engaging (Cases 1-4) with the framework, and as a smokescreen for continued poor performance.

5.6.3 Theme 3: Responses to QOF Surveillance

Three out of the five practices contextualised QOF monitoring as a tool of increasing government surveillance and managerial control through targets. The clinicians tended to be rather scathing of this climate, and saw it as further undermining their professional autonomy. Surveillance was also viewed in the context of increased computerisation and the reduction of practice performance to meaningless electronic indicators for the purpose of remote state control, disengaged from the day to day realities of general practice. However, resistance to surveillance proved difficult to sustain, with two of these practices implementing some organisational change to improve their QOF

performance in light of mounting pressure from their PCTs. Notably, one practice which continued to resist the framework underwent closure during the course of this study and resistance to QOF proved futile (Case 3). Clinically, one practice appeared to remain ignorant of QOF surveillance, due to a poor grasp of the framework (Case 4). Lastly, within Case 5, the response to QOF surveillance was also thematically salient. QOF surveillance technologies were embraced as part of its pre-existing paradigm of applying evidence-based standards, templates and systematic ways of working to improving patient care.

The descriptive account of the overarching themes presented here, will be analysed within the context of the literature in the theoretical discussion chapter which follows. First, a typology of the participating practices will be proposed.

5.6.4 Typology of Persistent Low QOF Scorers

To create a typology is to classify cases by certain commonalities or differences. Cases are grouped on the basis of attributes to create a meaningful classification. Typologies are therefore constructs dependent on the attributes that underpin them. These attributes are revealed throughout the research process and defined through empirical findings. Therefore, typologies are based on empirical investigations and provide meaningful statements about social reality. There is little systematic guidance as to how typologies should be constructed in social research, yet the notion of types has featured highly within it (Kluge, 2000). The process taken to create the typologies within this thesis is described in the earlier Methods chapter. Unlike those assigned by QOF, quantitative

labels which emphasise performance have been rejected and those which encapsulate data have been used.

The typology is as follows:

Table 3: Case Typology

Case	Type
1	Person-Centred Individualist
2	Struggler 1
3	Futile Resister
4	Struggler 2
5	Specialist Innovator

The features of the typology are presented in the table below:

Table 4: Typology Features

Type	Sense of In Practice Quality	Reported Change in Values as a Result of QOF	Implementation of QOF	Self-Directed Organisational Change as a Result of QOF
Futile Resister	Poor	None	No Change	None
Struggler	Adequate	None	Failing attempt	None
Struggler	Poor	None	Failing attempt	None
Person-Centred Individualist	Excellent	None	Delayed	Yes
Specialist Innovator	Excellent	None	Immediate	Yes

Memorable types have been assigned to the practice cases, along with a clear summary of the qualitative assessment of the level of care they provide. To summarise the features of the cases further, the level of change of values as a result of QOF is presented. Similarly, the typology is ordered in line with the level of QOF implementation evident within the practice. Whether or not the practice changed organisationally as a result of QOF is also forms part of the typology. In sum, the typology summarises the type of change at practice level for the same stimulus.

In the next chapter, the typology will be used to establish the findings of the thesis within the context of pre-existing and new theory. More broadly, the three themes presented in the overarching case, can be contextualised within a discussion of the limitations of QOF, and literature concerning professional values, managerialism & self-regulation, and responses to QOF surveillance.

6. THEORETICAL DISCUSSION

The theoretical discussion will summarise the main findings of the study and compare these to pre-existing literature. Developments for existing theory will be proposed. The strengths and limitations of the study will be analysed and suggestions for future research made.

Constructing a typology of low QOF scoring general practices has not previously been attempted. However, 'archetypes' of high performing sites in the States have been drawn up (Feifer et al., 2007). The authors of this study argue that the creation of typologies is a useful guide to understanding how practices interact with quality improvement. The typologies proposed by this thesis will be used throughout the theoretical discussion to facilitate understandings of the low QOF scoring practices and their responses to QOF.

6.1 Limitations of QOF

The typology proposed within the overarching case study, clearly highlights the shortcomings of QOF in capturing all facets of general practice quality. Two out of the five practices studied, from the perspective of a qualitative assessment, demonstrated excellent patient-centred care, which their QOF scores did not reflect. However, in ways that QOF can never truly capture, the remaining practices had intrinsic flaws with their organisational practices and knowledge of IT systems, problems with teamwork, and burnt-out GPs who were out of touch with recent professional guidance. They had evolved into chaotic organisations, unable to adapt to new practices, particularly in the face of a challenging deprived patient population. They were poorly performing in both

quantitative measures and in terms of the core values described by Marshall (2009) - excellence as medical generalists and commitment to whole person care in practice.

The Person-Centred Individualist practice's single-handed GP was a pillar of their community, knowledgeable about their patients and their families. They spent time with patients during consultations and had adapted a number of organisational practices in response to patient feedback. This practice had a small dedicated and cohesive staff team, also familiar with most of their patients, which the GP claimed to want to protect from the burden of additional QOF workload. The framework was deemed to be largely meaningless according to the GP and did not facilitate capture of true quality, rather detracted from patient need through the imposition of bureaucratic indicators by PCT management. The findings for this case strongly chimed with the established discourses of performance monitoring undermining GP professionalism, whereby this practice's lead was committed to self and peer regulation and took offence with a remote and intrusive regime.

However, with an increased threat of sanctions from the PCT, this practice began a delayed implementation of QOF, with the GP taking a professional lead over this process, with both setting up the IT infrastructure and putting together various protocols for the practice. However, this did not signal an internalisation of the principles of managerialism, the discourse of the pointless and intrusive nature of QOF remained, with the GP citing their continued commitment to person-centred values as proof of their true resistance against the regime. Here, from the Foucauldian perspective of panopticism, QOF did not create obedient subjects with a new value framework, rather ones that gave a token nod to QOF in order to stave off an increase in unwelcome managerialist interventions.

Therefore, this specific case clearly reinforces the previously explored dichotomy of patient-centred versus technology-centred care. Like quality, patient-centeredness is a complex and dynamic concept in itself. Certainly, there was an ethos of patient-centeredness, revealed through a qualitative assessment of a sense of care conveyed by the GP to their patients within the practice that was not only talked about, but ‘felt’ by the participant observer. From comfortable clean surroundings and friendly sensitive receptionists with local knowledge, to the accessibility of the GP in the waiting area and bars to tie your dog to whilst at the practice, the patients were very much at the centre of the operations of the Person-Centred Individualist practice. There was a very strong sense of value-driven professionalism in this practice, which, in line with the principles of the Professional Standards Authority (2016), was demonstrated in how the doctor behaved towards others, rather than the self-serving individual focus of the status the role of being a doctor affords. QOF, as a measurement-based tool, cannot facilitate an understanding of some of these nuances of what it means to deliver quality care. This is in keeping with the wealth of literature reviewed in the background chapter (e.g. Kordowicz & Ashworth, 2013; Heath, 2009; Lester, 2008 etc.).

In the case of the Specialist Innovator, the shortcomings of QOF as a general population-based tool were highlighted. This practice served a clinically specialist, chaotic patient population, rendering high achievement on QOF nigh on impossible. However, the attitude of this practice towards QOF was distinctly different from the Person-Centred Individualist. Here, QOF was embraced and a parallel QOF 2 was created with the involvement of the PCT to serve the needs of the practice population more closely. The practice worked with, rather than against, QOF in order to upkeep

its patient-centred values and professional identity as a local innovator on behalf of vulnerable groups.

This engagement is likely to have been influenced by the management discourses and principles which already featured highly within the day to day operations of the practice. For instance, the practice had a Business Partner, clear and flexible policies and procedures, numerous meetings, shadowing schemes and the like – all principles highly influenced private sector HR practices, and embraced in order to improve the organisation of the practice and delivery of patient care. This suggests that private sector principles which, as explored previously, are seen as being at odds with the public sector ethos, may in fact have a role to play in driving excellent organisational practices. Again, QOF was redundant in capturing quality of care in this case, which brings into question the alignment of QOF high performance with quality of care within public policy.

However, as can be seen from the typology proposed by this thesis, the remaining three practices (Futile Resister and the two Strugglers) did in fact demonstrate poor quality care in line with their QOF scores. It can be argued, therefore, that QOF can highlight cases of poor performance and interventions can be designed accordingly. The uniqueness of these cases, however, is the extent to which they failed to implement QOF in any tangible form over a number of years, seemingly remaining immune to PCT interventions to improve their performance. Eventually, of course, this was resolved in the case of the Futile Resister by the managerially imposed closure of the practice.

Interestingly, these three practices, along with the Person-Centred Individualist, used the discourse of professional values and patient-centred care as a rationale for not fully engaging with QOF. This can imply, therefore, that constructs of professional values can be used as a smokescreen for poor performance. There is some evidence from pre-existing ethnographic research that claims of professional clinical judgement are often used to normalise breaking rules (Dixon-Woods, 2010). To take this further, this process of legitimisation may not necessarily result in better more patient-centred care, but rather act as an excuse for not engaging with QOF.

However, this wasn't the case for the Person-Centred Individualist practice, where the single-handed GP appeared to be the embodiment of altruistic community-driven professionalism. The apparent on the surface similarities between the cases, be it as defined through QOF performance or value discourses, can detract from the day to day reality of the care the practices deliver. These findings therefore support a more qualitatively-driven approach to performance management in general practice, one which can uncover some of these subtle nuances and motivations of practices seemingly disengaged with quality improvement initiatives.

Interestingly, in all of the cases studied as part of this thesis, holding values of patient-centeredness was cited as the rationale for why the practices chose to reject QOF or underperformed on it. Though some practices demonstrated person-centred values in practice (Person-Centred Individualist, Specialist Innovator), others struggled to bridge the gap between their own rhetoric and reality of on-the ground care delivery within their practices (Futile Resister, Struggler 2). They perceived QOF to be at odds with the professional value of patient-centeredness that they held. It is, therefore, appropriate to unpick the concept of patient-centeredness further later in the discussion.

It appears that the Specialist Innovator in particular had employed a number of strategies to sustain person-centred care in the face of a policy and management culture of standardisation. Indeed, there was clear a culture within the practice of peer-support, providing the basis of local, creative approaches to delivering excellent care. The earlier literature review suggests that the opportunity for person-centredness may too often be undermined by the demands of externally mandated ‘quality’ programmes experienced as bureaucratic exercises which fail to acknowledge the complexities of delivering care within a patient-centred context and the intricate professional judgements this entails. Yet, within this practice the ‘bureaucratic’ apparatus was seen as aiding multi-faceted care excellence within individual patient consultations.

However, the value of patient-centeredness, overwhelmingly recurrent within the thesis’ themes across the cases, has undergone some criticism. Stemming from Rogerian (1951) principles of person-centred therapy, the term ‘patient-centred’ initially appeared in the magazine “Future General Practitioner” and was presented as a holistic approach to care, with the patient in their totality, at the centre of decisions regarding their treatment (Howie et al., 2014). However, over time the notion of patient-centeredness became very much viewed as an inherent part of general practice, and this may have harmed the developed of partnership working between primary and secondary care sectors, with hospital doctors not being viewed as ‘people’ doctors. In addition, although patient-centred care is cited as a necessity in achieving high quality care, this drive may in itself prove problematic. It has been argued that true engagement with patients is tough, demanding work and hard to sustain in day-to-day practice (Swinglehurst, 2014).

Unlike QOF indicators, patient-centredness is difficult to define. Mead and Bower (2000) argued that whilst patient-centred care is increasingly regarded as imperative to high quality care, how it is defined and measured in terms of process and efficacy remains unclear. Yet, despite some of the ambiguities surrounding the definition of patient-centred care identified by Mead and Bower, some randomised controlled trials have been carried out (e.g. Kinmonth et al., 1998; Chenoweth, 2014), particularly around chronic disease management, comparing the effectiveness of patient-centred care with its non-patient-centred counterpart. The findings of these studies generally support the inclusion of person-centred dimensions within clinical care, suggesting that the concept can in fact be defined and operationalised within practice.

Additionally, Mead and Bower propose that there are a number of dimensions to the concept – the biopsychosocial perspective, 'patient-as-person', sharing power and responsibility, therapeutic alliance, and 'doctor-as-person'. The practices studied proposed similar notions of person-centredness, whereby they described themselves as striving to provide the best care based on their individual patients' needs and this was perceived by them as stemming from a long-term relationship with their patients and the wider community. Yet, there remains a question mark over how realistic it is to provide patient-centred care at all times. There is, of course, a power asymmetry between the doctor and patient in terms of knowledge and usually physical vulnerability at the point of consultation. For the doctor to consider all elements – popularly coined 'biopsychosocial' factors to capture the multifaceted nature of human behaviours - that contribute to the person who sits before them, and within the time-constraints of a five minute consultation, is unlikely to be feasible. Whilst the doctor/patient relationship is an important facet of patient definitions of quality care,

the patient also expects the general practitioner to make quick and appropriate decisions regarding their care, drawing on their own professional knowledge and experience (Wen & Tucker, 2015).

Howie and colleagues (2004) analyse some of the assumptions about core general practice values, including patient-centred care. 'Patient-centeredness' is presented as a multidimensional concept in their paper and is primarily concerned with the involvement of patients in their care. Yet, the paper also highlights whether the push for patient-centeredness may, paradoxically, ignore the very desires of the patients themselves. They cite other authors who have demonstrated that certain groups of patients, such as the elderly and more seriously ill, prefer clinician led care (McKinstry, 2000; Savage & Armstrong, 1990). Naturally, a truly patient-centred approach would take account of these desires also, and not blindly push for patient involvement. Howie and colleagues conclude that the concept is hard to define, measure and deliver. This also led them to state, as discussed in the background chapters, that general practice quality in itself is a challenging construct.

Indeed, the typology presented within this thesis is the researcher's data-driven, but nonetheless personal and socially constructed (in keeping with the epistemological standpoint of this thesis), take on the level of quality offered by the practices studied - quality that in some cases QOF has not been able to capture, categorising two excellent practices as 'poor-performers'. On the other hand, it could be argued, that QOF rightly highlighted the low performance of the practices in three out of the five cases. Nonetheless, only a qualitative study of this sort would elucidate the themes at play within poor performing practices, such as the tensions between professional values and

managerialist frameworks, in ways that QOF cannot. The next section of the discussion will focus on these very themes.

6.2 Professional Values, Managerialism & Self-Regulation

In line with Pettigrew's ideas (1992), the Specialist Innovator Practice was receptive to QOF. Pettigrew argued that mixed teams which combine managerial as well as clinical and nursing staff, as in the case of the Specialist Practice, are more effective in progressing strategic change. The practice, therefore, had already embraced certain managerialist discourses, and therefore embraced QOF within its pre-existing paradigm. Notably, all of the other practices participating in this study, did not have a practice manager. It could be argued that an effective management infrastructure is required to perform well on QOF, particularly in light of the bureaucratic and administrative demands it makes on the practice.

However, the other four participating practices all demonstrated the professionalism/managerialism tensions that abound in the literature reviewed in earlier chapters. Notably, there was a clear element of effective self-regulation within the Person-Centred individualist practice, outside of the bounds of managerialist frameworks, through regular meetings with peers within the locality, which likely contributed to the delivery of excellent care. Formal regulation such as QOF may well undermine subtle relationship-based self-regulation, which may be particularly dangerous in the field of risk management (Fischer & Ferlie, 2013), where more informal systems of regulation are crucial. The theme of self-regulation and reactions to calls for greater transparency features highly within the cases.

All of the practices were proud of their ability to self-regulate, with varied consequences. It appears that those who self-regulated, but along with seeking external professional regulation and guidance from colleagues and professional bodies (i.e. The Person-Centred Individualist – Case 1 and the Specialist Innovator – Case 5) provided excellent care. In addition, the Specialist Innovator, embraced transparency, whereas the Person-Centred Individualist practice remained resistant to it until PCT intervention meant that adaptation had to take place. The remaining poor performing practices were very much isolated from the normative relationship-based input of other professionals, which was no doubt enhanced by their single-handed status, and language barriers in two out of the three – the Strugglers.

To place this in the context of a Foucauldian theoretical framework, one can relate the concept of professional relationship-based regulation to Foucault's (2005 & 2010) ethics-oriented mode of governing the self. Foucault explored notions of formative and perverse notions of governmentality. Formative governmentality encapsulates subjective relational self-regulation. On the other hand, introducing a top-down surveillance-based framework for performance, leads to a perverse governmentality with unintended consequences. Parallels can be drawn here with high QOF performance being criticised for becoming an end to itself, rather than a means to an end (Heath et al., 2009).

In this vein, the two excellently performing practices studied (The Person-Centred Individualist and The Specialist Innovator) held almost a meta-knowledge of the 'smoke and mirrors' nature of a preoccupation of displaying good conduct through QOF. They claimed that there is no point to either implementing (in the case of The Person-Centred Individualist) or pushing the agenda (in the case of The Specialist

Innovator) of QOF, as such organisational behaviour wouldn't directly benefit patient care or uphold their professional values. Parallels can be drawn with the work of Roberts (2009), who argues that an excessive concern with producing displays of high performance distorts social practices detrimentally and restricts self-knowledge.

The findings of this study also suggest that QOF did not alter the professional values of person-centred care held by the practice, regardless of whether those values were enacted in reality and went beyond smokescreen rhetoric. However, some commentators have noted that there are many complex layers to the relationship between managerialist modes and the medical profession. To present this relationship purely as a dichotomy is short-sighted. Indeed, the Specialist Innovator practice had established a pragmatic collaboration with the PCT, whereby they had created their own version of QOF to fit the practice's own organisational paradigm. This allowed the practice to preserve their professional identity whilst working within the remits of new organisational modes (Reay & Hinings, 2009). Others have argued that the clear-cut division between managers and clinicians is a fallacy, with clinicians increasingly appropriating managerial discourse into their work (Doolin, 2002).

Indeed, in the case of the Specialist Innovator, their organisational model of clinical and non-clinical partners, seemed to be an indication of a hybridised way of working and a reflection of embracing management to ensure the effective growth of the practice. Within the Person-Centred Individualist practice, the single-handed GP was actively involved in a number of advisory and local Health Trust management bodies, again taking on board elements of leadership, but ones that chimed the GP's professional values. It is of interest that the two practices which were qualitatively assessed to deliver excellent quality of care, were ones which engaged with managerial

discourses, but in ways which fitted their own values of person-centred care. On the other hand, the Futile Resister and the Strugglers appeared to lack the tools and communication skills to meaningfully interact with and, to some extent, understand managerialist mandates.

It can be proposed therefore, that top-down, remote approaches to engaging with consistently low QOF scoring GP practices with information technology performance management tools are unlikely to be successful without a recognition of values and local demand. 'Buy in' is likely to be achieved by recognising and embedding GPs' professional values into the design and implementation of quality improvement frameworks. Additionally, local understanding of the practice is essential, as in the case of the local QOF version developed with the Specialist Innovator, and remote management is likely to isolate the practitioner.

In contrast to some assumptions made in the background and literature review chapter, practices did not discuss financial motivators for engaging with QOF and a theme of financial incentives did not emerge from the data. Rather, the theme of patient-centred care within the scope of professional values remained salient throughout the study. Yet, it is also worth noting that as GP practices operate as small businesses, an outright rejection of financial gain over patient-centred care is thus an oversimplification. And indeed in order to survive and keep providing quality services to their patients, a GP practice must retain an income stream, which requires some conformity with state administration. Therefore, it would be of interest to explore how the low QOF scoring practices rationalise these conflicting values in the face of state bureaucracy.

Indeed, the conflicts between normative values and forms of order and power have been noted in the literature (Boltanski, 2011). The next section of the theoretical

discussion will now focus on responses to QOF surveillance and the extent to which these may be mediated by pre-existing value paradigms within consistently ‘poor’ performing general practices.

6.3 Responses to QOF and Surveillance

Within the thesis’ background chapters, Checkland and Harrison’s (2010) qualitative study of the impact of QOF on practice organisation and service delivery was discussed. This discussion can now be expanded by drawing on the findings of the thesis. Unlike the participants of Checkland and Harrison’s study, four out of the five of the case studies had failed to implement the changes in infrastructure required to perform successfully on QOF. In some of the studied practices (Futile Resister and the Strugglers), there appeared to be an inability stemming from lack of management skills and a lack of technological knowledge, to adapt roles and processes to facilitate QOF. Interestingly, this lack of competency also reflected the lack of service and organisational quality within the practices.

However, it is not so much that QOF captured the poor performance, rather it was the inability to implement a QOF reporting process which led to the practice’s low scores. The Specialist Innovator already had a strong IT infrastructure in place, a large team, and effective management, to which QOF, in the words of the practice’s business partner, *‘added an additional string to our bow’*. With numerous tools in place in the practice designed to support holistic care of patients with mental health problems (e.g. the care planning approach), QOF was not only readily implemented, but also adapted to work best with the practice’s own organisational paradigm. Due to a culture of

‘recording data and form filling’ within the practice, QOF was not seen as labour intensive. Parallels can be drawn with the King’s Fund Report (2011) which suggested that a pre-existing IT infrastructure plays a part in QOF acceptance.

Hence, QOF did not undermine the professional and managerial knowledge of the practice, and in some respects similarities can be drawn with Checkland and Harrison’s theme of general practices undergoing ‘no change’ and instead fitting QOF around current performance. Again, this raises questions whether engagement with QOF itself improves performance, or is it rather a ‘pay for reporting’ pre-existing performance scheme (Lester, 2008).

Lastly, the Person-Centred Individualist practice did begin to implement the infrastructure required to improve QOF performance through increased reporting and computerisation. This finding is in line with Checkland and Harrison’s study, which argues that QOF implementation goes hand in hand with an improved technological and organisational infrastructure. Yet, contrary to Checkland and Harrison’s paper, which suggests that QOF becomes readily ingrained alongside practice re-organisation, dissent can be found within the cohort of England’s ‘poorest’ performing general practices. Simply through the reluctance of the Person-Centred Individualist, the improvement of the organisational infrastructure was delayed, as was the implementation of QOF.

Most importantly, Checkland and Harrison conclude that general practices offer little resistance to surveillance, which is becoming increasingly normalised and accepted as a useful tool for quality capture and improvement. However, the findings of this thesis provide a striking contrast to this theory. Four out of the five practices studied were

critical of increased monitoring and saw it as an undesirable threat to their professional autonomy. In fact, their resistance or reluctance to engage with the scheme was rationalised by the narrative of top down surveillance undermining patient-centred care. It clear here, that the study of the uniqueness of outliers has enabled a shift in understanding towards there being a range of response of general practices to QOF.

On the other hand, the Specialist Innovator, a large practice with a highly influential in-house arm of management, had already internalised managerialist discourses as part of its professional identity. This lent itself well to the incorporation of QOF into their existing organisational and value paradigm. Thus, the findings of the thesis suggest that the cautionary concepts reviewed at the start of the thesis regarding the effects of top down surveillance on professional values taken from the seminal works of Freidson and Foucault should continue to be paid heed in today's regulatory climate.

However, the thesis findings do challenge the Foucauldian notion that surveillance creates obedient subjects with new self-identities. Despite mixed interactions with QOF, none of the practices studied in this thesis developed new self-defined identities on the basis of QOF. Instead, they either maintained effective self-regulation, or re-emphasised their professional value-based identities as rationale for resisting the framework. Externally, the identity of the futile resister did change significantly, as the practice underwent closure, in part as a sanction for its poor QOF performance. It could be argued that the typology in itself has created new identities for the practices in the form of fixed labels. However, the typology was seen as a method of capturing pre-existing and, at times, self-defined facets of a practice within a concise classification, rather than as a means of assigning new identities to the study's participants.

In their study of responses to the system of ‘Choose and Book’, Greenhalgh and colleagues (2014) concluded that resistance of clinical professionals is an intricate concept, encompassing a number of complex facets. Therefore, purely behavioural interventions (of which QOF is one, as explained earlier in the thesis) are unlikely to achieve clinician engagement with the introduction of a top-down quality improvement scheme.

The findings of this thesis suggest that the facets which play a significant part in GP resistance to such schemes are their deeply entrenched professional values. In a similar vein, Greenhalgh and colleagues’ study also supports the importance of an awareness of those values as informing the clinician’s notions of quality over potentially over-simplistic numerical labels. The typology introduced above and which stemmed from the overarching case study, demonstrates the shortcomings in labelling low QOF scorers purely as ‘poor performers’. The typology presents a number of features which fall outside of the over-simplistic label of ‘poor-performer’.

However, according to McDonald (2014), it should be noted that models of responses to quality improvement initiatives tend to assume rationality. Whilst a clear rational and thought out approach to the implementation of QOF was evident in two out of the five cases (Specialist Innovator and Person-Centred Individualist), the other three practices (Futile Resister and the Strugglers) remained rather chaotic in their response to QOF, torn between and sporadically reactive to, if at all, the day to day organisational demands of their practice.

The concept of rationality can be linked to the role of professionalism in influencing standardised responses to incentive schemes and can also be expanded to include a

collective rational professional response. Of course, notions of the collective voice tend to be products of the study of the majority. Therefore, it is hoped that this study was able to contribute to a greater understanding of the nature of some of the dynamics which may affect responses to QOF amongst low scorers and thus ‘non-rationality’ within a professional group.

A further argument posed by McDonald concerns the need to understand ‘logics’ which guide values and behaviours and therefore responses to QOF. McDonald’s concept of ‘logics’ easily lends itself to the professional/managerial dichotomy reinforced by the findings of the thesis. McDonald notes that ‘competing logics’ often co-exist. However, their opposing nature breeds forms of resistance to obstruct the dominance of a new logic. Certainly, in the case of the Futile Resister and the Person-Centred Individualist, the resistance towards QOF was clear, and according to the participants, was the direct result of the managerialist logic of QOF being at odds with the professionalism logic they held. Despite the same logics underpinning these practices’ resistance to QOF, both the quality of care they offered and resistance outcomes for the practices were strikingly different. The Futile Resister was a chaotic practice, failing to provide organised, timely patient care and lacking in sufficient resources, managerial capability and technological skills to adequately serve its practice population. The practice continued to resist the QOF regime, with only very superficial efforts made to demonstrate QOF implementation, used to fend off the PCT for as long as possible, rather than to improve the care or even more simply the recording of care for their patients. During the course of the fieldwork, the practice underwent closure.

On the other hand, the Person-Centred Individualist practice’s single-handed GP self-identified as an altruist, driven by the needs of their local rural community, offering a

personalised, family-based approach to care, maintaining a status of a pillar of the community. This self-perception was very much aligned to the qualitative assessment of the practice; clearly, this practice provided a person-centred, caring approach, spending time with each patient and approaching their care holistically, within the context of local biopsychosocial knowledge. Indeed, as discussed previously, it may be easier to resist QOF as the sole senior figure in an organisational hierarchy, without the normative effects of a partnership or group (Campbell et al, 2009). Yet, as can be seen in the case of the Futile Resister and the Strugglers, a lack of normative influence in general practice can be detrimental to its performance and the quality of care it provides. This Person-Centred Individualist practice, however, eventually had to cave in to the demands of QOF surveillance. Increasing pressures from the PCT resulted in the QOF implementation infrastructure being put into place, notably the recruitment of a practice nurse and improved information technology, and the development of new ways of working was underway at the time of the study, nonetheless with the GP single-hander continuing to maintain professional control over the initiative.

However, it could be argued that the risk of closure in this otherwise excellently functioning practice was far less likely than in the case of the Futile Resister, not least because of its rural location far from alternative service provision, and the near to irreplaceable nature of the established local care it delivers. It appears that the organisational impact of QOF as described in the background chapters, would not be too dissimilar within the Person-Centred Individualist practice, albeit with some delay, due to initial resistance to the scheme, driven by the logic of professionalism. Yet, this thesis points to the need for an understanding beneath the layer of competing logics, in order to grasp the mechanisms surrounding the resistance to top performance

monitoring and quality improvement initiatives. In line with McDonald, more nuanced responses to managerial reforms within general practice need to be accommodated. Next, the implications for practice and future outlook will be appraised.

6.4 Implications for Practice & Future Outlook

Naturally, 'quality' will remain a complex problem and to drive its improvement data have to be 'meaningful, accepted and acted on' (Howe, Mathers & Steel, 2012). This thesis demonstrates that what lies at the core of high quality care is greater than that which can be captured through measurable indicators (Kordowicz & Ashworth, 2013). This is clearly one of the challenges for the new CCGs and NHS England. While it is claimed that by placing the GP at the centre of local decision making we can work towards true quality, it is simultaneously of great importance that a reductionist approach, despite easily lending itself to policy creation, does not overshadow the nuanced aspects of what it means to deliver quality in general practice.

A further consideration for practice, evidently surrounds the need for performance management schemes not to undermine professional values, but rather be aligned to them. Parallels can be drawn here with Marshall's (2005) claim that though financial incentives will continue to play an important role in quality improvement, their success will, however, only be maximised if the impact of financial incentives appeals to the intrinsic motivations and values of health professionals. This no doubt holds important implications for practice and could inform 'quick wins' for those designing incentive frameworks. Therefore, ownership over the design and implementation of indicators

should belong to the scheme's target audience and be aligned to their professional values.

Furthermore, this study supports the calls of Kordowicz & Ashworth (2013) for the development of qualitative quality indicators primarily focusing on excellence and more clearly capturing the narrative of a primary care which so often goes the extra mile, and beyond. However, in a climate of austerity and resource limitation, it is unlikely that such a scheme will materialise presently. Nonetheless, Dixit (2003), suggests that empirical research should not make sweeping generalisations about the success or failure of incentive schemes. Instead, success or failure should be related to specific characteristics or domains, such as multiple dimensions and observability of inputs and outputs. Practitioners should look at the organisation as a whole.

Throughout the course of the research, it became apparent that some of the low scoring practice participants not so much felt that the indicators themselves were problematic, rather the intrusive nature of QOF monitoring led to tensions. This again can be linked to Marshall's argument that predominantly bureaucratic quality improvement frameworks are less likely to sustain the motivation and engagement of clinicians. Therefore, 'tick box' type schemes should only be concerned with technical and tangible aspects of care (e.g. recording smoking status), rather than the more complex less definable features of general practice (e.g. psychosocial elements of a consultation). In many ways QOF already holds some of these features. General practitioners are actively involved in the development of QOF indicators and, broadly, the indicators are concerned with measurable aspects of patient care (e.g. blood pressure readings, HbA1c levels etc.). Perhaps, the problem lies not so much with the design of QOF itself, rather with QOF performance becoming synonymous with

general practice quality. As the findings of this thesis have demonstrated, labelling practices as ‘poor performing’ purely on the basis of their QOF scores, does not present a complete picture of the quality of care that a practice delivers, nor the intricacies of where their failures in performance may lie.

In line with Chouliaraki and Fairclough’s (1999) work on clinical/managerialist hybrids, the low QOF scoring participants of the study which were qualitatively excellent performers, balanced managerialist demands against the imperatives of professionalism. This was achieved by blending applicable management discourse with a professional one to create hybrids. However, to add to Chouliaraki and Fairclough’s conceptualisation, a key feature of the hybrids observed in the study within the Specialist Innovator Practice was that they were constructed only by taking on managerialist facets which did not undermine pre-existing professional values. It can therefore be assumed that managerialist principles are not internalised, rather they are adapted to fit deeply rooted professional values.

Yet, in line with the present Conservative government’s policy zeitgeist of strengthened clinical leadership for quality improvement, attempts at engaging GPs with clinical commissioning have been mixed. A review of the literature on the subject by Miller and others (2015) reveals a variation in clinical engagement with commissioning schemes. It appears that programmes which allow clinicians to retain their professional autonomy were more likely to result in greater engagement. The findings of the thesis support that – the participants of this study valued their professional independence.

In some of the studied cases, professional autonomy was used as a justification for not making positive organisational changes within their practices, or improving the level of care provided to their patients. Here, professional autonomy remained outside of

professional normative mechanisms, such as engagement with local guidance and colleagues. The Person-Centred Individualist practice's GP valued their autonomy whilst playing an active role in local professional membership organisations and keeping abreast of clinical research and guidance to implement this into their practice.

Furthermore, a second parallel of this study with the work of Miller and colleagues is that the failure of organisational programmes to engage GPs leads to disengagement. Indeed, in four out of the five cases a lack of buy in or capability to implement QOF bred a clear disengagement with and, at times, a rejection of it. Writing about commissioning, Miller and colleagues highlight the importance of GP engagement in policy mandates in order to engender change and progress. To draw on an editorial by Howe, Mathers and Steel (2012), which claimed that organisational approaches underpinning quality of care are relatively simple, but may be undermined by regulatory demands, the findings presented within the thesis suggests that a return to the intrinsic values which truly motivate primary care staff, namely providing care focused around patient need, will go a long way towards engaging clinicians with quality improvement drives. The authors call for greater GP leadership within such an undertaking.

Yet, there may be a number of constraints to GP leadership being enacted in reality. Martin and Waring (2013) argue that creating frontline leaders as a tool for improving service quality can prove problematic, as leaders within the NHS are often limited in their ability to enact their leadership roles. The study suggests that the key constraints general practitioners may face in management positions are pre-existing managerial hierarchies and institutional structures which are difficult to negotiate. In addition, it is

likely that within a climate of financial cuts and austerity, the resources may not be available for GP leaders to enact their leadership goals.

Martin and Waring indicate that leadership takes a more muted form in reality, through alignment with pre-established managerial relationships and mandates. This finding can be related to clinical/managerial hybridisation explored earlier in the thesis, whereby clinicians seek to maintain an element of professional autonomy by accepting the managerial discourses best aligned to their values. Therefore, to apply this to future outlook, the implications for practice may be that clinical commissioning must be driven by clinical patient-centred, rather than managerial considerations. Though it is also worth noting that the push for professional values must take into account facets traditionally considered to exist within the remit of management, primarily organisational and financial considerations, in order to make appropriate service decisions. However, these should be seen as the tool for achieving patient-centred care, rather than an end in itself.

Within the theme of perceptions of QOF, a number of participants expressed not being adequately recognised or rewarded for their seemingly labour intensive QOF work. In line with Burgess & Ratto (2003), team-based financial rewards may be preferred to direct payment to the GP principal. This is particularly appropriate in contexts where co-operation is important for the outcome of the organisation or where only aggregate measures of performance are available – both of contexts being relevant to QOF. So as not to undermine intrinsic motivation, investing the financial rewards gained from better performance in creating an improved working environment (e.g. new equipment and facilities for staff) could also be an optimal alternative to individual financial

bonuses in organisations where workers have a strong intrinsic motivation. This may also create greater engagement for the practice team.

The findings of this thesis support those of O'Donnell, Jabareen and Watt (2010), who discovered that post the introduction of QOF, practice nurses complained about the dramatic increase in workload and that their financial rewards had been less than expected, given the financial gains for practices. The two Strugglers, had made some attempts at implementing QOF in their practice, however often these attempts had been led by the administrative team, with little managerial oversight from the GP Principal. These two practices notably did not have a practice manager or a practice nurse. Therefore, attempts to carry out QOF work, were often chaotic and sporadic, fitted in around more pressing demands of administrative and reception tasks. The infrastructure required for high QOF performance (McShane & Mitchell, 2015) had not been put into place and managerial tools barely utilised.

Despite this thesis presenting a view that rather sides with professional values and public sector altruism over market principles, a balanced view dictates that this should not preclude an openness to the application of traditionally private sector principles to achieve improvements within the healthcare sector. For instance, strategies and tools taken from the rather disparate information technology and manufacturing industries (e.g. PRINCE2, Lean etc.) have in some cases proven to be successful in raising healthcare service performance (e.g. Proudlove, Moxham & Boaden, 2008). This chimes well with Marshall's (2009) calls for the NHS learning from industry to improve its organisational performance and to explore the usefulness of transferrable solutions, which have reaped rewards within the business and manufacturing sectors. Of course, given the huge complexities and distinct areas within the healthcare sector,

feasibility studies need to be undertaken to make sure that these solutions are applicable and likely to be engaged with.

Next the strengths and limitations of this study will be analysed.

6.5 Strengths and Limitations of Study

The key strength of the study was gaining unprecedented access to persistently low QOF scoring practices. Prior to this study, there were no known published attempts to qualitatively research how these practices operate. They were considered to be largely unapproachable and out of reach of external parties. Furthermore, such seemingly disengaged general practices seemed to create a challenge for policy makers and quality improvement initiatives. Applying an impartial, sensitive approach to the recruitment process, helped to engender a sense of trust, allowing me to absorb myself in the day to day life of the practices studied as a participant observer for a significant period of time. This no doubt allowed for rich data to be gathered, helping to form an in depth understanding of how practices labelled as ‘poor performing’ really function.

The thesis also revealed the shortcomings surrounding the use of QOF to judge overall performance and define quality of care in general practice. An ethnographically-informed methodology allowed for rich reflections and analysis, rooted in an experience of a practice and its staff, along with a ‘triangulation’ of various sources of qualitative data to form in depth case studies.

The methods used within the study do not hold generalisability to the wider population, as is the usual case with qualitative research, as was previously unpicked within the methods chapter. This is of course due to the low number of cases studied and the in-

depth study of them naturally resulting in much variation. To argue generalisability would also detract from the aim of qualitative research, which is to elucidate the uniqueness of the phenomena studied. The goal of this PhD was to gain a greater understanding of ‘outlier’ general practices and therefore generalisability would not have been possible to achieve or even relevant.

However, there is an element of transferability to the findings. Transferability refers to the degree to which the results of this thesis can be transferred beyond its bounds. Transferability implies that the findings of this study can be applied to similar settings. Clearly, the knowledge derived from this thesis, can shed light on general practice performance and responses to pay for performance schemes in future. In addition, it may have applicability to other healthcare settings, as well as helping to aid an understanding of the effectiveness, or lack of thereof, regulatory frameworks in the public sector more broadly. The thick description of the cases explored within this thesis enables future researchers to compare its findings with those they may see emerge in their own work.

The key transferable findings centre around meanings of quality beyond the QOF, responses to QOF surveillance amongst ‘poor’ performing QOF practices and a greater understanding of some of the tensions between professionals and managerialist frameworks. These findings can be usefully applied by policy-makers and other contributors designing incentive schemes and proposals for their implementation. The findings may also be of interest to other GP sites struggling with a sense of top-down performance management seemingly undermining their sense of values. Other sites may indeed find parallels with some of the case studies presented in this thesis and how they chose to deal with this tension.

Whilst this study has enhanced previous theoretical models for understanding the responses of general practice professionals to top down government monitoring, it has failed to include the patients voice, which should be at the centre of engagement (and similarly disengagement if seen at odds with patient-centred values) with quality improvement schemes. Furthermore, the findings of the study may lack wider applicability to understanding what drives engagement with quality improvement initiatives, as it does not include data from practices which are engaged with the scheme with successful QOF outcomes. However, both of these issues could not be tackled within the time constraints of a PhD thesis.

There are some limitations related to the construction of typologies, which were explored within the methods chapter. Typology in itself, as discussed previously, is not to be seen as a static entity rather than as a flexible starting point for understanding low QOF scorers. Furthermore, the typology can be adapted to fit other healthcare settings, which appear to resist quality improvement frameworks. It should also be noted, that ‘low scoring’ is not a typology in itself and it is a reductionist label which doesn’t recognise the variation with seemingly ‘poor’ performance. The typology could usefully be applied to classifying healthcare organisations that do not respond to performance management frameworks. The typology promotes the understanding that values are unlikely to change as a result of quality improvement drives, regardless of the level of quality of care within their services. The typology could be utilised for designing tailored interventions to raise the quality of care within the practice, but also in recognising that interventions may not be deemed necessary, as ‘poor’ performers may provide excellent care beyond the scope of metrics.

In light of the study’s limitations, suggestions for future research will now be made.

6.6 Suggestions for Future Research

Notably, a study of patients' perceptions of low QOF scoring practices would have enhanced the findings of this study and facilitated constructs of quality, patient-centred care from the user perspective and the extent to which QOF is an adequate capture mechanism for the definition of quality from the patient perspective.

In terms of further research concerning the study's participants, their subsequent QOF scores could be sourced, in order to see whether the participants managed to successfully shed their 'poor performer' label. The practices could then be re-visited to gauge what drove the changes in their QOF scores. The longitudinal nature of such additional research would add greater validity to the case constructions and resulting typologies.

Moreover, engagement linked to values has consistently featured within the findings and analysis of this study. It has been seen that professionals can block change (Ferlie et al., 2005). No doubt, professional engagement with quality improvement initiatives and performance management is key to their feasibility and success. Marshall and Harrison (2005) note that there is much that we do not know about how best to use engagement through incentives to change the behaviour of health professionals. In particular, it is essential that we develop a deeper understanding of the relationship between incentivised and non-incentivised professional work. Therefore, value-based strategies to engage outliers both qualitatively and quantitatively could be evaluated. Whilst this study strongly suggests that an appeal to the professional values of the clinicians, in particular upholding patient-centred care, is key to their engagement with quality improvement, future qualitative research ought to be utilised to identify some of the meanings and features of engagement and the management tools which facilitate

it amongst primary care professionals. In a climate of increased ‘on the ground’ inspection with the rise of the CQC regulatory regime, it would be of interest to gauge whether or not a non-remote process of performance management results in greater professional engagement.

7: CONCLUDING REMARKS

This is the first time hard to reach QOF ‘poor’ performers and their responses to regulation have been studied through an ethnographically-informed research process. The methodology of this study facilitated an in depth understanding of low QOF scoring general practices, therefore achieving the primary objective of the study. It is now conceivable that GPs who do not prioritise achieving high QOF scores are able to remain outstanding holistic practitioners, central to preserving high quality care. This thesis is important in recognising the values driving ‘poor-performing’ general practices and some of the constructs surrounding their responses to QOF surveillance. General practice quality is multi-faceted, and QOF is a limited framework for defining it. This thesis has demonstrated ways in which low QOF scoring practices interact with performance management and how these interactions are influenced by professional values. In order achieve greater engagement of outliers, performance management must appeal more directly to the values driving general practitioners and their teams.

The study contributes to knowledge by attempting to reframe current understandings of responses to surveillance and by presenting a typology of persistently low QOF scoring general practices. To conclude the theoretical discussion, it is worth revisiting Foucault’s quote at the very beginning of this thesis: *‘The Panopticon is a marvellous machine which, whatever use one may wish to put it to, produces homogeneous effects of power’*. The practices studied have taught us that far from being homogenous, the effects of power and top-down surveillance are varied and can only be fully understood beyond the realms of the ‘marvellous machine’. In the present era of GP-led commissioning, it is key that reductionist performance management tools do not overshadow the finer aspects to what it means to deliver quality care in general practice.

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APPENDICES

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APPENDIX 1: FIRST PROJECT PROTOCOL

Research Protocol

1. Title

Understanding General Practice Performance: An Ethnographic Study of General Practices with Low Quality and Outcomes Framework Scores

2. Abstract

Background

The Quality and Outcomes Framework (QOF) is the dominant tool for measuring 'quality' in general practice. There is some evidence that organisational culture, which may be more difficult to measure, impacts on performance and quality in healthcare. Some general practices have continued to have the lowest QOF scores nationally since the framework's inception in 2004, suggesting that QOF may not be appropriate or relevant to these practices. It is therefore of particular interest to capture the attitudes to QOF within these practices and explore their organisational cultures, which are likely to lie beyond the scope of QOF.

Aim

The key objective of this study is to gain a greater understanding of the general practices in England which have had the lowest QOF scores nationally over a five year period. This study is being conducted for the purpose of a doctoral thesis, leading to the award of PhD.

Methods

Five practices will be selected purposively, based on location, from a cohort of 141 general practices in England, scoring the lowest 10% of QOF scores nationally. These practices will be studied ethnographically, employing the methods of participant observation, one-to-one semi-structured interviews and documentary analysis. Data in the form of field notes, interview transcripts and practice documentation will be analysed using interpretive thematic analysis.

Results

Overarching themes relating to organisational culture and concepts of quality and performance from the perspective of the participants, as well as from the ethnographies of the studied general practices, will be presented. These will be illustrated with data excerpts, including non-attributable participant quotes.

Discussion

Findings increasing the understanding of low scoring QOF practices will be discussed. This study will add to the ongoing debates around the understanding of and methods for capturing quality in general practice, including the limitations of QOF as the dominant framework used for this purpose.

3. Background

Since its inception in 2004 as part of the General Medical Services Contract, the Quality and Outcomes Framework (QOF) has become the dominant model for monitoring the quality of primary care general practice services in England on a 'pay for performance' basis. Improving the quality of patient care within a targets framework has become a key preoccupation within health services (Elwyn & Hocking, 2000).

A literature search of EMBASE and Medline electronic databases, using the search term 'Quality and Outcomes Framework' suggests that research in the field of primary care quality indicators focuses on practice performance on individual indicators (e.g. Ashworth et al, 2008). Furthermore characteristics of general practices in England are largely defined using quantitative methodology (e.g. Gabhain et al, 2001). Although it is argued that targets significantly shape the way that healthcare is delivered in primary care (Rhydderch et al, 2004), it is also apparent from longitudinal studies in the field that some practices continue to underperform (Ashworth et al, 2010).

Therefore a study of an exploratory nature would fill the gap of capturing the qualitative features of those poor performing practices. Low QOF scoring practices are of particular interest as their continued underperformance may indicate a lack of willingness to engage with QOF and an inappropriateness of the framework to the practice. Gaining a greater understanding of how these practices function as organisations may challenge the widely-accepted concepts of 'quality' and 'performance' which drive policy and the quality improvement agenda in primary care.

The link between how a practice functions organisationally and the quality of the service it delivers has been made within published literature. For instance Huntington and Gillam (2000) discuss the challenges limiting organisational features of general practices pose in nationwide quality improvement programmes. This connection between a practice's organisational features and the level of its performance provides justification for this study's central purpose of identifying the organisational culture of low QOF scoring general practices.

Moreover there is a breadth of literature pointing to the limitations of target frameworks in identifying the problems which impede the performance of public services (e.g. Hood, 2006). As QOF is the dominant framework for capturing practice quality, it is of interest to ‘get under the skin’ of those practices to which QOF may not be appropriate, beyond the scope of measurable targets. It is also hoped that by gauging the organisational dynamics that limit the performance of practices, this study will contribute to the field of healthcare services research by identifying means of improving practice performance and therefore the quality of patient care.

There has been an emergence of qualitative literature employing the ethnographic approach to the study of healthcare organisations and the impact of QOF on general practices (e.g. McDonald et al., 2009; Grant et al., 2009), but none attempting to gain a greater understanding of practices which have continued to underperform on QOF. The ethnographic approach with its roots in anthropological study of tribal cultures, is the chosen mode of elucidating the cultures specific to the QOF-defined tribe of ‘poor performing’ general practices.

4. Statement of research questions/objectives

Therefore the primary research objective borne from the review of literature is as follows:

To gain a greater understanding of general practices which have had low Quality and Outcomes Framework scores over a five year period.

The secondary objectives of the research are to explore the following:

Do the low scoring general practices share a common organisational culture?

Why do some practices continue to underperform on the Quality and Outcomes Framework?

What do the low scoring general practices do well beyond the scope of the Quality and Outcomes Framework?

How relevant is the quality improvement agenda to low scoring practices?

How can the low scoring practices improve their ‘performance’?

5. Experimental design and methods

Design

The design of the study is qualitative and exploratory, employing ethnographic methodology.

Participants

Five general practices will be chosen from a cohort of 141 low QOF scoring practices. This cohort has been identified through a retrospective longitudinal analysis of publicly available national QOF outcome data since QOF's inception in 2004, using both descriptive and inferential statistical methods. Indicator points achievement within the lowest performing 10% of practices nationally was used as a cut off point to define the sampling frame.

The selection of five practices will be purposive on the basis of practice location, representing the North and South of England, as well as urban and rural settings. It has been decided that five practices will be chosen to increase the potential of transferability of findings to other general practice settings, yet also for the study to be completed within the time constraints of a PhD course.

Within each practice, a purposive sample of staff members representing the range of general practice professions will be interviewed (i.e. GP, Nurse, Receptionist, Practice Manager etc.), until data saturation point is reached (i.e. no new information emerges). It is therefore envisaged that around 20 to 30 interviews will take place for all the participating practices. Minimal participant information will be collected, namely age, sex and job title.

Recruitment

The lead GP within each practice will be approached by telephone in the first instance. They will then be provided with an information sheet if interested in the study and the lead GP will be given two weeks to decide whether or not to take part. If the lead GP agrees to include their practice in the study and has read and understood the content of the information sheet, written consent will be sought from them and an information sheet will be forwarded to them to be distributed to the practice staff.

Written consent will be sought from the practice staff members at the first mutually agreed practice visit, which will take place at least two weeks from the staff receiving information sheet, giving them time to decide whether or not to take part in the research.

All practice staff will be able to opt out from the observation and/or interview elements of the study.

The lead GP will be offered a £200 payment to the practice account as a reimbursement for working time lost due to practice research participation.

Procedure

The ethnographic tool of participant observation will be employed. The researcher will observe the day-to-day life of each practice (excluding patient consultations) over five days. These visits may or may not be consecutive, depending on convenience, as well as emerging data. The researcher will be making field notes throughout and will endeavour to take part in practice activities such as practice meetings, in order to embed themselves more fully in the daily reality of the practices being studied.

The interviews will be semi-structured, with questions being exploratory in format, rather than leading. The ordering of the questions is flexible, to allow the schedule to be adapted to the participant and the direction of their responses. This also gives the interviewer the opportunity to explore themes emerging in the interview which were not previously considered.

The participants will be interviewed for up to 45 minutes, in a private room within the practice, such as a consulting room when not in use.

Interview questions have been formulated as a direct result of literature searches in the medical, medical sociology, healthcare management and organisational study fields, with a particular focus on factors which are thought to influence performance and engagement with quality improvement initiatives (see interview schedule Version 1.0). The interview questions have been piloted with the following general practice professionals: two GPs male and female, one Healthcare Assistant, one Receptionist, one Nurse Practitioner, one Practice Manager. The feedback of these participants about the questions was incorporated into the final interview schedule.

Emerging findings from the participant observation, as well as interviews, may need to be triangulated by sourcing practice documents, such as policies and guidelines. Patient notes will not be accessed.

Data Analysis

Data in the form of field-notes, interview transcripts and document content will be analysed using interpretive thematic analysis, with the aid of the software NVivo.

Thematic analysis focuses on categorising, analysing and reporting themes within data. It is likely that a framework of analysis along the lines of the five phase model of thematic analysis (Braun & Clarke, 2006) will be employed, using levels of coding in order to generate overarching themes with sub-themes. Thematic analysis is suited to the phenomenological aims of this study, namely its concern with increasing understanding of practice culture and the subjective experiences of key players within the general practice organisation.

Member checking will be carried out by asking the participants to comment on the accuracy of the themes and amalgamating their feedback with the data. The resulting themes will be checked for inter-rater reliability by colleagues, using a sample of anonymised raw data.

Reflexivity

Throughout the study, the principles of reflexivity will be applied, in order to allow for the recognition of the existence and impact of researcher bias within the research process. Reflexivity can be defined as an awareness of the researcher's own contribution to the construction of meanings and an acknowledgement of the impossibility of remaining impartial to one's subject matter. It is an awareness of the dynamics between the researcher and the studied practices. Ways in which the researcher's personal perspectives construct the research interpretation will be reflected upon.

6. Ethical Considerations

The principles of informed consent, confidentiality and the right to withdraw will be adhered to throughout the study. Written consent will be collected at the first visit to the practice prior to the data collection phase. Participant observation and interviews will not take place until consent to participate has been voiced by the participants. Contributions of those practice staff members not consenting to taking part in the participant observation element of the study will not be included in the thesis or any resulting publications.

In order to preserve confidentiality and anonymity, no participant identifying details, other than designation, age and sex will be printed in the final thesis and any resulting publications. Contributions to the study will not be shared between the participants, nor will participation between the participating practices. Data will be stored in an anonymised fashion, whereby participant codes will be used rather than identifying details.

It is in the interest in of the study to keep the research unobtrusive, so as to keep the situations observed as natural as possible. However some disruption to daily work with the researcher observing, asking questions and conducting interviews is unavoidable. However this disruption will be kept to a minimum, particularly in patient areas, so as not to affect the level of patient care. Patient consultations will not be observed. Any patient information linked to identifiable patients revealed through the course of the study will not be used in the research.

The interview questions have been designed to be as neutral as possible so as not to cause the participant distress. In the event of misconduct or malpractice coming to light, this will be raised with the study's supervisor in the first instance, who is bound by the General Medical Council's Code of Conduct.

It is likely that exists a stigma around being labelled a poor performing QOF practice, as well as a fear of reprisal from regulatory bodies. To counteract this, the research process will be kept open and collaborative, so as to make sure it does not have an

‘inspection feel’ about it. The researcher will explain their activity within the practice to participants regularly, revisit consent, and participants will be able to view all field notes if requested and give feedback on findings.

7. Project Timetable

2010

May-July: Recruitment phase

September-January: Practice visits for the purpose of data collection

August-December: Data collation and interview transcription

2011

January-February: Data transcription

March-June: Data analysis

July-November: Results write-up

December: Paper writing for publication

2012

January-February: Paper submission for publication

March-August: PhD writing up

August: Dissemination of findings/publications to participants

14th August 2012- PhD Thesis Submission

8. Benefits of the Study

Low scoring QOF practices are a largely unstudied group and this study will add to the understanding of those general practices for which QOF may not be the most appropriate method of quality improvement. The study will explore the concepts of ‘quality’ and ‘performance’ from the point of view of the low scoring practices. The study may contribute to knowledge by producing a typology of poor performing practices. Conversely, as QOF is the dominant framework for measuring performance, it is hoped that the what these ‘poor performing’ practices do well beyond the scope of QOF will be elucidated through qualitative enquiry.

Through utilising the ethnographic approach, this study will contribute to current thinking about the usefulness of interdisciplinary organisational study to healthcare settings. By conceptualising the responses of the participating practices to quality improvement initiatives, the study may propose methods for policy-makers and

managers of engaging ‘unenthusiastic’ general practices with such drives, thus offering greater opportunities for improving patient care.

9. Resources and Costs

This study is funded by the Department of Primary Care and Public Health Sciences, Division of Health and Social Care, School of Medicine, King’s College London. The researcher is in receipt of a three-year full-time departmental PhD studentship and has access to training and conferences and subsistence budgets earmarked for this study.

10. References

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APPENDIX 2: PARTICIPANT INFORMATION SHEET

Study title

‘Understanding General Practice Performance’

Invitation

My name is Maria Kordowicz and I am a PhD (doctoral) student at King’s College London with a background in Psychology. I would like to invite you and to take part in my PhD research study. Before you decide whether or not you would like to take part, you need to understand why I am conducting this research and what it would involve for you. Please take time to read the following information. Talk to others about the study if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The purpose of this study is to increase the understanding of ‘performance’ in general practice. Of particular relevance to this greater understanding is the exploration of how practices which have low Quality Outcomes Framework (QOF) scores perceive and respond to QOF, especially in light of QOF being merely a snapshot of good primary care.

The key aims of this study are to learn about what your practice does well beyond the scope of QOF and the types of incentives and motivations that drive you and your colleagues at work. A more general aim of this study is to further the understanding of how general practices function as organisations.

Why have I been invited?

You have been invited because you are a GP or a team member of a general practice which has over the past five years been one of the 141 practices in England with the lowest 10% of QOF scores. As this may be an indication of the inappropriateness of QOF to your practice, it is particularly important to me to hear your views about QOF.

I would also like to learn about the differences in how practices function nationally and am therefore recruiting urban and rural practices in the North and South of England. I hope to study 4-5 practices altogether.

Do I have to take part?

It is completely up to you if you decide to join the study. I will be asking you to sign a consent form at my first visit and this gives you options of whether you want to take part in the observation part of the study, be interviewed, or both.

What will happen to me if I take part?

This research is an ethnographic study. This means that I will be observing the day-to-day

work of your practice most likely on five separate occasions and I hope that this will take place with minimal interruption to your day. I am particularly interested in the things your practice does which are not captured by QOF, such as providing patient-centred care. During this time I will be making notes. I may also ask you questions and attend your practice meetings. If you have decided not to take part in the observation part of the study, I will not record any of your activities I may have observed.

Additionally, I want to find out what your views are of QOF and about how your practice functions. I intend to do this through one-to-one interviews with individual practice staff members. It is totally up to you whether or not you would like to be interviewed.

What will I have to do?

As my research is an ethnographic study I will simply be observing what goes on in your practice day to day, so in this respect all you have to do is carry on about your day as you would usually and I hope to interrupt you as little as possible. I may however ask you questions to clarify situations which may be meaningful to me as a researcher. I may also ask to get involved in some of the work going on at your practice or to attend practice meetings or to have a look at certain practice documents. I am likely to be making notes, which you can always ask to see. I will **not** be sitting in during patient consultations.

I will also be conducting interviews with those members of the staff team who would like to be interviewed. This would take up to 45 minutes, in a quiet private area of the practice, such as one of your consulting rooms and what we say would be recorded on a Dictaphone. I have designed the questions so that they are not too personal; they cover topics such as teamwork, your opinions of QOF and how your practice functions. But as everything you say will be kept confidential, I hope that you will feel able to speak openly.

If you are the lead GP at the practice or the practice manager, I suggest that you introduce my study to your staff at your next practice meeting, or informally if you do not normally hold meetings, so that the team is aware of my visits. I would welcome the opportunity to speak at your practice meeting so that your team knows what taking part in this research study involves and so that I can introduce myself formally.

Will I get paid for taking part?

You will not be paid for taking part directly, however as a goodwill gesture a sum of £200 will be paid to the practice at the end of my work at your practice as a reimbursement for lost time and interruption caused by the research.

What are the possible disadvantages and risks of taking part?

As taking part does not involve much beyond your usual working day, the risks of taking part are minimal. The main disadvantage is being disturbed at work, however I really intend to keep disruption minimal as possible as the point of the study is to observe your practice as it usually is.

What are the possible benefits of taking part?

I hope that it will be of interest to you to have the opportunity to discuss your experiences of working at your practice and exploring ideas about what affects the performance of your practice, as well as exploring how QOF affects your work day to day, if at all. Above all I want to give practices for which QOF may not be appropriate a 'voice' through my research.

What happens when the research study stops?

Once I leave your practice and have conducted all the interviews at your practice, I may contact you for further information before the PhD thesis is submitted at the end of 2012. I will share a synopsis of my findings with you either by email or letter, whichever you prefer. I hope to publish my findings in peer-reviewed journals. The name of your practice and the names of staff members will be kept confidential and will not therefore be used in the thesis or published.

What if there is a problem?

As this study is for the purpose of an academic PhD course, it is closely supervised and any problems are reviewed on a weekly basis with my supervisor, Dr Mark Ashworth, or immediately if necessary. The opportunity to complain through King's College London procedures will be available to you. You may also withdraw your participation from the study at any time.

Will my taking part in the study be kept confidential?

Yes. Furthermore the name of your practice, its location or any identifying practice characteristics will be kept anonymous in the PhD thesis and any resulting publications. Similarly so will any identifying characteristics of individual members of staff from the practices. Data in the form of interview transcripts and field notes will also be coded so that only I and my supervisor can identify the source of the data. If participants are quoted verbatim in the thesis, any identifying phrases or words will be removed and the quote will be attributed to for example 'nurse 1, practice 1' in order to maintain confidentiality. Similarly data sourced from the practice will be kept confidential within that practice and between the practices I study. This means that I will not share any information you give me in confidence or research data pertaining to you or the practice you work at with your colleagues or with other practices taking part in the research.

However in the unlikely possibility of misconduct coming to light through my research, I will report this to my supervisor in the first instance who will decide on the appropriate channels for dealing with the issue.

If I come across any patient information in the course of my time at the practice, for example I may hear a discussion of patient cases at a practice meeting, this will not be recorded anywhere and will not be used in the research.

What will happen to the results of the research study?

The results of the research study will be used first and foremost in the production of my PhD thesis. I also plan to publish peer-reviewed journal articles to disseminate my findings and present them at relevant conferences, whilst upholding the confidentiality of the study participants at all times.

In keeping with King's College London guidance, anonymised data will be stored for seven years after the study has finished.

Who is organising and funding the research?

The research is for my PhD course at the Department of Primary Care and Public Health Sciences, Division of Health and Social Care Research, School of Medicine, King's College London. It is funded by a three year departmental studentship.

Who has reviewed the study?

My research proposal and the progress of the study are regularly reviewed by my supervisor, Dr Mark Ashworth and colleagues within the Department of Primary Care and Public Health Sciences at King's College London.

The study has received ethical approval with a favourable opinion from the National Research Ethics Service, Brighton West Research Ethics Committee [ref: 10/H1111/15].

Further information and contact details:

Please contact me with any questions at this stage and throughout the course of the study:

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If you have any concerns or comments that you feel need to be raised with my supervisor, his contact details are:

Dr Mark Ashworth – Clinical Senior Lecturer
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APPENDIX 3 CONSENT FORM

Study Name of practice:

Participant identification code:

title: Understanding General Practice Performance

Name of researcher: Maria Kordowicz

Please tick box:

	Yes	No	N/A
1. I confirm that I have read and understood the information sheet dated 19.02.2010 [Version 1.0] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.			
2. I am the lead GP for the practice I agree to my practice being included in the above study.			
3. I agree to take part in the observation part of the above study and for the use of non-attributable quotes of what I say in the study.			
4. I agree to be interviewed for the above study, for the interview to be voice recorded and for the use of non-attributable quotes of what I say in the study.			
5. I understand that my participation is voluntary and that I am free to withdraw my contributions from the study at any time without giving reason.			

Name of participant (please print):

Job title:

Sex (please circle): M/F

Age:

Signature:

Date:

Name of person taking consent:

Signature:

Date:

1 copy for participant, 1 copy for researcher

APPENDIX 4: INTERVIEW SCHEDULE

1. What in your opinion makes a good general practice?
 - 1.1 How would you define good and bad quality of care?
2. How would you describe the general practice you work in?
 - 2.1 How does it function?
 - 2.1.1 What are the IT systems like? Is the administrative support adequate?
How about the building itself? (Impact of single-handed status?)
 - 2.2 What kind of organisation is your practice?
 - 2.3 Would you say that it has a particular culture as an organisation?
 - 2.4 How well do the practice's staff work as a team?
 - 2.5 What factors influence the quality of care provided in your practice?
 - 2.6 How closely do you work with other organisations? E.g. other practices, PCT, universities?
 - 2.7 How could the way the practice functions be improved, if at all?
3. What influences the performance of your general practice?
 - 3.1 What are your practice's aims/priorities?
 - 3.2 How is performance measured in your practice?
 - 3.3 What individual GP /staff characteristics, if any, are related to the quality of care provided at your practice?
 - 3.31 Do you feel that the practice being single-handed influences its quality in any way?
4. What is working for this practice like?
 - 4.1 What are the employee benefits working for this practice?
 - 4.2 What provision is there for staff teaching and training?
 - 4.3 Do you dislike anything about working for this practice?
5. What influences your performance at work?
 - 5.1 What motivates you to perform well?
 - 5.2 What guides your work/clinical practice?
 - 5.2.1 What role does professionalism play in your practice?

- 5.3 Are there any incentives formal or informal to reward work at the practice? What are they?
6. What are your thoughts on the Quality and Outcomes Framework?
- 6.1 How important is QOF at your practice, if at all?
- 6.2 Does your work involve contributing to the QOF? If so, how?
- 6.3 How has QOF affected your practice, if at all?
- 6.4 What are your thoughts about the practice being paid for its performance in general/for meeting the QOF targets?
- 6.5 To what extent does QOF capture the work of your practice?
- 6.6 What affects your performance on the QOF?
- 6.7 Are there any particular elements of QOF that are difficult for your practice to engage with? Why?
- 6.8 How has your performance on the QOF affected your practice? How does it affect your practice if you do not do so well on the QOF?
- 6.9 What would help your practice to increase its QOF scores?
- 6.10 Do you think that QOF could be improved in any way, if at all? What other quality indicators would best capture the work you're doing at your practice?
7. How do you involve your patients in the life of the practice?
8. And finally what in your opinion does your practice do well?

APPENDIX 5: INTERVIEW QUESTIONS MAPPED WITH SELECTED SUPPORTING LITERATURE

1. What in your opinion makes a good general practice?
 - 1.1 How would you define good and bad quality of care? (**Campbell, 2000**)
2. How would you describe the general practice you work in?
 - 2.1 How does it function?
 - 2.7.1 What are the IT systems like? Is the administrative support adequate? How about the building itself? (Impact of single-handed status?) (**Westland et al., 1996; De Koning et al., 2005**)
 - 2.8 What kind of organisation is your practice?
 - 2.9 Would you say that it has a particular culture as an organisation? (**Schein, 2004; McDonald et al., 2007; Hann et al., 2007**)
 - 2.10 How well do the practice's staff work as a team? (**Stevenson et al., 2003; Proudfoot et al., 2007; Wiener-Ogilvie, 2008**)
 - 2.11 What factors influence the quality of care provided in your practice?
 - 2.12 How closely do you work with other organisations? E.g. other practices, PCT, universities? (**Ferlie & Shortell, 2001**)
 - 2.13 How could the way the practice functions be improved, if at all? (**Huntington & Gillam, 2000**)
3. What influences the performance of your general practice?
 - 3.2 What are your practice's aims/priorities? (**Proudfoot et al., 2007**)
 - 3.2 How is performance measured in your practice?
 - 3.3 What individual GP /staff characteristics, if any, are related to the quality of care provided at your practice? (**Ashworth et al., 2010**)
 - 3.31 Do you feel that the practice being single-handed influences its quality in any way? (**Van den Hombergh et al., 2005**)
4. What is working for this practice like?
 - 4.1 What are the employee benefits working for this practice?
 - 4.2 What provision is there for staff teaching and training?
 - 4.3 Do you dislike anything about working for this practice?

5. What influences your performance at work?
 - 5.1 What motivates you to perform well? (**McDonald et al., 2007**)
 - 5.2 What guides your work/clinical practice?
 - 5.2.1 What role does professionalism play in your practice?
 - 5.3 Are there any incentives formal or informal to reward work at the practice? What are they? (**Maclure, 1982; Campbell et al., 2009; Power, 1997**)
6. What are your thoughts on the Quality and Outcomes Framework?
 - 6.1 How important is QOF at your practice, if at all? (**Grant et al., 2009; Rhydderch et al., 2004**)
 - 6.2 Does your work involve contributing to the QOF? If so, how? (**Grant et al., 2009**)
 - 6.3 How has QOF affected your practice, if at all? (**Gabhain et al., 2001**)
 - 6.4 What are your thoughts about the practice being paid for its performance in general/for meeting the QOF targets?
 - 6.5 To what extent does QOF capture the work of your practice?
 - 6.6 What affects your performance on the QOF? (**Keenan et al., 2009**)
 - 6.7 Are there any particular elements of QOF that are difficult for your practice to engage with? Why?
 - 6.8 How has your performance on the QOF affected your practice? How does it affect your practice if you do not do so well on the QOF?
 - 6.9 What would help your practice to increase its QOF scores?
 - 6.10 Do you think that QOF could be improved in any way, if at all? What other quality indicators would best capture the work you're doing at your practice?
7. How do you involve your patients in the life of the practice? (**Unger et al., 2000**)
8. And finally what in your opinion does your practice do well?

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APPENDIX 6: EXAMPLE OF FIELD NOTES

any time now. He then says well let's see how today goes.

- In the meantime the receptionists deal c telephone queries - they then go through into Dr. room to clarify issues (this feels like hard work).
- 10.45 ~~no~~ more patients appears to deal c park.
- 11.15 Dr. pops out to do home visit without saying 'bye'.
- Issues with fax no. @ Diabetic clinic.
- Pts pop in c queries & ask receptionist how her holiday was.

APPENDIX 7: EXAMPLE OF INTERVIEW TRANSCRIPT

I – Interviewer

P – Participant

I: So it's started recording.

P: OK

I: So to begin with, because this is quite an unusual practice, could you tell me a bit about how you ended up working here, what draws you to this particular area of work?

P: Practice was opened in 2001 by the lead GP, who at that point was Dr. (name withheld), and I actually worked with Dr. (name withheld) in mainstream practice, we worked together for a few of years and he got the contract for setting up (practice name withheld) and asked if I would like to kind of help him and set up and open it. So there was myself, (GP name withheld), (specialist nurse prescriber name withheld) and two receptionists who joined on day one. And it went from there really.

I guess what drew me was, well when I had... one - I thoroughly enjoyed working with (the GP name withheld), two – it was an opportunity to set something up from scratch for a client group that in (PCT name withheld) the majority of GPs were no longer willing to prescribe for. So we had probably about 95% of practice in (PCT name withheld) were not willing to prescribe methadone. (GP name withheld) had quite a few of them on his list in mainstream practice and obviously they're a very vulnerable and fragile client group and most people see them as a nuisance in mainstream, so it was kind of putting the plans together for a green field PMS site for a practice specific for addictions. So we applied for the contract and got it. So the attraction for me really was setting up something from new. Actually setting up a practice from nothing to see what it would grow into and to provide the best service possible for a client group that were getting a very poor service to kind of try to work on their health needs and their addiction needs and set the service up to fit them and not to fit the system, if that makes sense? Because they weren't fitting into the system. Because they don't always turn up to their appointment on time, they don't always want to be in the waiting room, they don't ring and cancel their appointments. So we came very much from a different ethos to mainstream it was very much if you turn up on the same day we'll still see you, because it was very important to keep them in treatment and build up a relationship.

So it was kind of exciting – the challenge. So we started on day one, there was five of us and a zero list size. We got premises seven days before we were due to open and we got the budget four weeks before we were due to open. (GP name withheld) went out to ad for staff on his own credit card, because we didn't have a budget agreed, they just kept saying 'it'll be agreed, it'll be agreed', but we got to the point that I said 'actually if we don't ad for two frontline staff, we won't be able to open

APPENDIX 8: EXAMPLE OF DOCUMENTARY EVIDENCE GP STATEMENT & PRACTICE INFORMATION LEAFLET

G.O.F. & my story

On the 31st March, it was difficult to say which emotion was more prominent sadness or happiness. There was sadness and depression because we were leaving the practice after twenty two years of hard work and because of the uncertainty of work in the future. There was happiness and relief because we were getting away from the P.C.T.'s harassment.

We filled thirty one boxes of Lloyd George notes and filled twelve big brown bags with rubbish. Our courier Bob collected them and put them in his big van. "How many bags are they?" I asked Bob. He did not reply as though it was irrelevant, I repeated the question he told me that he did not know as he had cleared out many G.P.'s surgeries in recent months. It was cleansing of single handed G.P.s who had always been treated as cinderellas by the PCTs.

When I first started out as a G.P. I had a partnership with a doctor who signed a contract with me however he did the same with two other G.P.'s and terminated the contract before it was finished. So I started off a single handed practice by myself in south east London.

Many Vietnamese were among the first patients to register and they spoke no English. Many had come to England after spending eight or nine years in camps. It was very difficult to get them settled as their lack of knowledge of the language and way of English NHS caused problems. I had to communicate through a Vietnamese interpreter. Getting them to trust the NHS was initial treated several for pulmonary.

Next came the Africans in treating them was a matter of matters. When the vast leaving the ethnicity was discriminated against with immigration services. Having tried to establish what for this information.

After that Somalians came ruling tribe. Many were One man asked me to treat wounds on his scalp. Or Again they spoke no English care. Many of the elder cases includes voodooism

This area seems to attract a similar position as each

Disabled access
The practice premises have suitable access for

How to register
Apply at the reception

Services available
General Medical Services
Obstetric Services
Family Planning
Cervical Cytology
Vaccination & Immunisation
Ear Piercing
Dispensing
Child Surveillance
Minor Surgery
Private Medical Examinations (including off

Opening Hours of the premises
9am to 6pm Mon, Tue, Thu & Fri
9am to 11.30 Wed

Consultation Hours
10 am to 11 am Mon to Fri
5 pm to 6 pm Mon, Tue, Thu & Fri

Antenatal Clinic
2 pm to 3 pm Thu

Method of obtaining access to services
In person or by phone

APPENDIX 9: EXAMPLE OF PILOT NVIVO ANALYSIS USING CODING STRIPES

The screenshot displays the NVivo software interface for a pilot analysis. The main window shows a text document titled "pilot int 4 general practitioner" with a coding stripe applied. The stripe is labeled "concepts of quality" and is positioned over a paragraph of text. The text in the stripe reads: "Q: What in your opinion makes a good general practice?" followed by a detailed response about general practice, mentioning stakeholder perspectives, role of strategic apex, patient-centredness, and concepts of quality.

The right-hand pane shows a coding density chart for the "concepts of quality" stripe. The chart displays the following data:

Concept	Density
stakeholder perspectives	100%
role of strategic apex	100%
patient-centredness	100%
concepts of quality	100%

The bottom of the interface shows a list of sources and nodes. The sources list includes "pilot int 4 general practitioner" and "pilot int 5 general practitioner". The nodes list includes "concepts of quality", "stakeholder perspectives", "role of strategic apex", "patient-centredness", and "concepts of quality".

APPENDIX 10: LIST OF AUTHOR'S THESIS-RELATED CONFERENCE PRESENTATIONS

Kordowicz, M. (2010). The Impact of QOF in General Practice – A Qualitative Synthesis. Poster Presentation Society for Academic Primary Care National Conference, East Anglia University.

Kordowicz, M. (2010). The Impact of QOF in General Practice - A Qualitative Synthesis. Poster Presentation Postgraduate Fair, King's College London.

Kordowicz, M. (2010). The Impact of QOF in General Practice – A Qualitative Synthesis. Plenary Oral Presentation Qualitative Research in the NHS Conference, Cambridge.

Kordowicz, M. (2012). What are poor performing general practices really like? Findings from three case studies. Oral Presentation Society for Academic Primary Care Annual Conference, Glasgow.

Kordowicz, M. (2013). What are poor performing general practices really like? Findings from five case studies. Poster Presentation Society for Academic Primary Care Annual Conference, Nottingham.

APPENDIX 11

AUTHOR'S THESIS-RELATED PUBLICATIONS

- A. Ashworth, M. & Kordowicz, M. (2010). Editorial: Quality and outcomes framework - smoke & mirrors? *Quality in Primary Care*, 18(2): 127-131. (pg. 277)

- B. Kordowicz, M. & Ashworth, M. (2010). Smoke and mirrors? Informatics opportunities and challenges of the Quality and Outcomes Framework. In Siriwardena, N. & Gillam, S. (eds) (2010). *How the Quality and Outcomes Framework is Transforming General Practice*. Oxford: Radcliffe. (pg. 283)

- C. Kordowicz, M. (2010). Viewpoint: research governance – assailing a paper mountain. *British Journal of General Practice*, 60(580): 862. (pg. 293)

- D. Ashworth, M., Schofield, P., Seed, P., Durbaba, S., Kordowicz, M. & Jones, R. (2011). The use of performance indicators to define a cohort of poorly performing general practices in England: a longitudinal study based on data from the 'Quality and Outcomes Framework'. *Journal of Health Services Research & Policy*, 16: 21-27. (pg. 295)

- E. Kordowicz, M. (2012). Do systems and complexity theories aid our understanding of poor performing general practices? *Journal of Contemporary Development and Management Studies*, 2: 1-11. (pg. 306)

- F. Kordowicz, M. & Ashworth, M. (2013). Capturing general practice quality – a new paradigm? *British Journal of General Practice*, 63(611): 288-289. (pg. 318)

A: Quality and Outcomes Framework: smoke and mirrors?

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ABSTRACT

Since its inception in 2004 the Quality and Outcomes Framework (QOF) has become embedded in the fabric of day-to-day general practice. Yet despite some of its tangible successes, the QOF's vulnerability to gaming poses challenges to its applicability as the dominant quality improvement framework in primary care. This paper questions whether high QOF scores amount to better care or simply the illusory effects of better data recording. Suggestions for developing QOF are made in the light of its limitations as a public health improvement initiative.

Keywords: exception reporting, gaming, general practice, primary care, quality improvement, Quality Outcomes Framework How this fits in with quality in primary care.

How this fits in with quality in primary care

What do we know?

The Quality Outcomes Framework (QOF) is the largest pay-for-performance (P4P) quality improvement initiative in primary care in the UK. Since its inception in 2004, general practice QOF scores have continued to rise, indicating improvements in, for instance, the management of diabetes and control of cardiovascular risk factors in diabetic patients.

What does this paper add?

This paper explores the successes of the QOF, as well as its shortcomings as the dominant method for capturing quality in primary care, arguing that some of the QOF's achievements may be illusory. The QOF's vulnerability to data distortion and gaming is discussed and its consequent limited applicability as a public health improvement initiative is highlighted.

Introduction

The QOF has in many ways been a triumph. A triumph of hope, because hopes have been high about the potential of the QOF to promote the quality agenda in primary care; and a triumph of expectation, as this revolutionary change in working practices for primary care teams has been incorporated into the everyday routine of practice life. It is hard now to imagine consultations with patients and strategies for practice management without the ever present spectre of the QOF. Whether it is QOF 'alerts' (reminders)

appearing unbidden on the computer screen during the consultation, motivational presentations about QOF targets within reach, or the more general acceptance in primary care that the QOF strengthens our public health role, it seems that QOF has succeeded in becoming part of the

fabric of general practice. Yet to what extent do these apparent successes of the QOF merely represent a smokescreen masking the real picture within primary care? Despite its tangible successes, assumptions about the QOF's power to capture and improve quality in primary care need to be revisited.

Key successes of P4P

The performance of primary care against the QOF proved to be far higher than was expected at the time the QOF was introduced.¹ The Department of Health based calculations around pay on an expected QOF score of 750 at the end of the first year (2004–2005). In fact, the 8600 general practices in England had a mean QOF score of 958.7 (out of a maximum possible score of 1050 points) which represented 91.3% of available points.² Two hundred and twenty-two (2.6%) of these practices achieved the maximum score. In spite of several annual revisions to the QOF, revising targets upwards and adding indicators, the 2008 to 2009 mean QOF score achievement was 954.2 of available points (the maximum is currently 1000 points) with 2.0% of practices achieving the maximum score.³

Achievement of high QOF scores brought with it higher performance-related pay than expected. Higher pay and a sense of professional pride have translated into better morale for general practitioners (GPs).⁴ This, in turn, has offered some easing to the recruitment crisis of the early 2000s, when international recruitment drives in Europe seemed to be the only way of filling GP vacancies.

These gains have also translated into public health gains, albeit on a rather piecemeal basis. The weighting of QOF points, since they reflect a pay deal for GPs, is driven by the assumed workload attached to achieving each indicator and not by the likely benefit to patients. Thus, for example, the indicator DM23 (at least 50% achievement of an HbA1c target of 7.0 or less for diabetics) is awarded 17 points whereas DM18 (influenza vaccination target of 85% for diabetics) merely attracts three points. Moreover, many of the public health indicators within the QOF such as blood pressure, cholesterol and HbA1c control were improving before the arrival of the QOF. Nevertheless, there has been evidence of public health gain, with substantial improvements in, for instance, the management of diabetes and control of cardiovascular risk factors in diabetic patients.⁵

A further public health success has been the drive to reduce health inequalities. The differences in QOF achievement between deprived and prosperous areas have been small and, over time, there is evidence that these differences have diminished.⁶ The narrowing of target differences between rich and poor communities has been part of an overall trend of improved performance, with slightly greater improvements seen in more deprived communities.⁷

Illusory successes?

There can be no doubt about the concrete improvements since the QOF was instituted in terms of overall quality improvement and 'intermediate outcomes' such as blood pressure and cholesterol control. However, the successes of QOF have been tempered by concerns that some of the achievements might not be as substantial as they appear.

One reason for questioning the success of P4P in its incarnation as QOF is that three technical features of QOF may have diminished the reach of performance targets.

First, the process of 'exception reporting' necessarily allows certain patients, deemed 'unsuitable', to be excluded from the overall target for patients registered at the practice.⁸ Patients may understandably be excluded if they are terminally ill or if they do not agree (after three written requests) to attend an appointment at the surgery for the management of their chronic disease. The overall exception reporting rate for 2008 to 2009 was 6.88% for indicators measuring an outcome and 1.70% for indicators measuring a process. So, on average, almost 7% of patients in England are excluded from public health targets such as achievement of a serum cholesterol of < 5mmol/l.

Second, the targets are not set at 100%. Again this is understandable given the practical difficulties of achieving clinical targets. These targets are rarely achieved in research trial conditions, let alone in routine practice, even with often large financial incentives to spur on the team. However, targets set at 70% for blood pressure control or cholesterol control in coronary heart disease (CHD6 and CHD8) exclude 30% of patients from these public health targets. Thus, in combination with exception reporting, targets set below 100% may shift the focus of the practice away from harder to reach patients, in exchange for more efficient achievement of results.

Third, the prevalence of each of the 19 chronic diseases currently included in the QOF is not independently verified. A practice may simply have lacked vigour in building up their disease registers; patients who, for one reason or another, have not been coded or have been incorrectly coded will not be on the disease register. They will therefore be invisible to QOF targets and again the public health effectiveness of population targets will be further reduced.

The success of the QOF may be tempered in other respects. Performance may have improved in domains covered by performance indicators but remain static in areas out of the spotlight, such as rheumatological and gastrointestinal disease. Increasingly, there are suggestions that performance against current criteria has now reached a ceiling and that other approaches are needed to coax further improvements out of primary care.

Gaming and P4P

The subject of gaming and manipulation of target achievement is controversial. Gaming is not unique to the QOF and is probably a feature of all P4P systems. The National Audit Office report on the 2004 contract for GPs suggested that QOF income could be inappropriately boosted by deliberately removing patients from disease registers or by increasing levels of exception reporting.⁹ Although all general practices are given an inspection-type visit annually by representatives from their primary care trust, this may be insufficient to detect evidence at case level of inappropriate exception reporting or exclusion from disease registers.

Gaming may generate overlarge financial rewards in just a few practices. But how widespread a phenomenon is it? Some have suggested that gaming is endemic, but a more balanced perspective has emerged from the

Centre of Health Economics which concluded that practices could have treated 12.5% fewer patients without falling below upper QOF thresholds.¹⁰ This suggests that GPs have not taken the opportunity to produce a threshold gaming effect, whereby the quantity and quality of work can be reduced to the minimum needed to meet the target. In other words, GP practices had overshot targets to a much greater extent than the likely level of exception reporting.

Better care or better recorded care

Practices with more highly developed management infrastructures and a shared ethos of coding every possible QOF-related activity will inevitably have higher QOF scores at the end of the accounting year. Many apparent improvements in care amount to little more than increased conscientious coding. For example, a practice failing to reach the 90% target for retinopathy screening in diabetes (DM21) may find that this target is achievable simply by searching through scanned correspondence from the hospital diabetic clinic or local optometrist reported retinopathy findings.

Practices may be making economic decisions based on workload, time and the type of professional needed to reach the target. On this basis, a practice may make one of three decisions. It may decide that it is not cost effective to chase the final QOF point (achieving the 90% target for DM21 is worth five points) and remain below the top target. Or it may invest in additional

data input staff to find and code missing clinical data. Or, and most expensively, it may invest in additional medical personnel to examine, say, an additional ten diabetic patients in order to gain all five available QOF points.

It is these pragmatic decisions, based on perceptions of workload and reward, that have resulted in some commentators describing the QOF as not so much a P4P system, but a 'pay-for-reporting' system.¹¹ Better recording undoubtedly results in higher QOF points but arguably may not represent better care. Equally, low scoring practices may be less skilled at handling large data volumes and may not necessarily be providing poorer care. The care provided by low scoring practices has not been evaluated in peer reviewed studies and we need research information on whether these practices do offer high quality care (which is inadequately recorded) or whether care falls below acceptable standards.

The QOF can only measure a small proportion of all primary care or GP activity and it is possible that low scoring practices display excellence in other domains not captured by QOF, such as continuity of care, patient-centred consultation skills, diagnostic skills and the care of illnesses not included in the QOF.

The QOF – fine tuning a force for good?

Increasingly, proposals for strengthening the QOF are focusing on aligning the indicators and the associated QOF points with public health gains. Now that NICE has taken overall responsibility for QOF development, the expectation is that the QOF will develop along the lines of NICE guidelines and continue to favour clinical indicators with a strong evidence base.

In an evaluation of the QOF in its original incarnation, Fleetcroft et al concluded that there

was ‘no relationship between pay and health gain’, at least for the eight public health and preventative interventions which were included in their study.¹² This is perhaps unsurprising because the level of P4P financial reward was based on estimates of likely GP workload rather than on health gain for patients. However, if QOF continues to be generously funded, it has to be able to demonstrate that the money is well spent given that the opportunity costs of tying up healthcare funding in the QOF are considerable.

Professionalism is one driver of quality which is in danger of being ignored by the QOF. And yet it is a sense of professionalism, the accumulation of a body of specialist knowledge and wisdom placed at the service of society, and a public service ethos which in the longer term probably motivate GPs more than a financially driven P4P system. It is hard to see how any P4P system could reward the components of professionalism, as expounded by Downie.¹³

Finally, greater inclusion of feedback from patients in the overall spread of P4P indicators is being explored. Prior to 2008 to 2009, GPs simply gave out questionnaires to a selection of patients and ‘patient experience’ points were awarded on the basis of completed surveys and reflection on the results of these surveys. Since then a more rigorous approach has been adopted, with independent patient surveys conducted by polling organisations. GPs are now rewarded on the basis of responses to two questions about time taken to access an appropriate health professional (PE7 and PE8). The questions asked have been criticised as being politically driven; they do not ask about the consultation or perceived standards of care. Yet their inclusion does mark a new emphasis on rewarding GPs on the basis of patient feedback. One danger of this approach is the unintended consequence of less satisfied responses from patients in deprived communities which may result in more funding being directed toward practices serving populations with lower healthcare needs.

Conclusion

So is the QOF all smoke and mirrors, or has it produced real improvements in patient care? We have discussed evidence of its successes in the management of long-term conditions and of improved financial rewards linked to GP workload. However, we have also shown that the QOF is not immune from gaming behaviours and the opportunity for data manipulation through, for instance, reporting as exceptions patients who are harder to engage. Bold statements about the QOF’s power to reduce health inequalities ignore the subtleties of organisational behaviour change in the face of financial rewards. There is no doubt that the underlying essence of good primary care lies in soft data and therefore is unlikely ever to be fully captured through P4P initiatives – rapport, interpersonal skills, continuity of care (passion and compassion, even!) to name but a few. Yet with greater patient involvement in the primary care agenda, there is likely to be a move beyond QOF based targets to targets based on indicators which hold meaning for the patient. The challenge will be to ensure that these new indicators do not become a smokescreen.

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B. ‘Smoke and Mirrors? Informatics Opportunities and Challenges of the Quality and Outcomes Framework’

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Chapter summary

This chapter presents the informatics opportunities of the Quality and Outcomes Framework (QOF), whilst exploring the challenges this ‘pay for performance’ (P4P) initiative poses for capturing the quality of primary care. The successes of QOF data systems are evaluated in light of QOF’s vulnerability to gaming and manipulation. Furthermore the limitations of QOF’s use in research and as a public health improvement tool are examined.

Key points

- QOF has become has brought with it a wealth of previously unavailable informatics opportunities to primary care
- These opportunities are not without their limitations, which are linked to QOFs vulnerability to gaming in light of financial rewards for performance.

Introduction

QOF in many ways has been a triumph. It is hard now to imagine consultations with patients and strategies for day-to-day practice management without the ever-present spectre of QOF. Whether it is the QOF alerts appearing unbidden on the computer screen during patient consultations, motivational presentations about QOF targets within reach, or the widespread acceptance that QOF strengthens the public health role of general practice, it seems that QOF has succeeded in becoming part of the fabric of primary care.

The framework has brought with it new and improved data structures with previously unavailable opportunities for the collection, retrieval and application of general practice and patient information, with assumed potential for reducing public health inequalities. Yet there is a risk that the dominance of QOF informatics as the primary means of assessing general practice quality may lead to a misrepresentation of reality. Indeed behind the policy smokescreen of QOF performance being synonymous with the quality of care that a patient receives in general practice, lie questions surrounding the shortcomings of informatics produced within a P4P framework.

QOF required the implementation of information management and technology systems which were fit for the purpose of monitoring the performance of all general practices in England. The next section of this chapter discusses some features of this process.

QOF informatics & systems

Informatics in primary care is concerned with the management of data to enable specific interventions to be connected with changes in clinical indicators for a particular patient group.

The implementation of new data structures to capture the coding of QOF clinical indicators saw a move away from unorganised data at general practice level to data processed in context. In other words QOF brought with it the dawn of usable general practice information. QOF can therefore be viewed not only as a quality improvement initiative, but also as a tool for optimising the use of primary care information. Five years have passed since its inception and today QOF holds data covering 99.7% of registered patients in England.¹

A challenge of a data integration process of this scale was to implement information management and technology systems that were fit for purpose. This is where the national Quality Management and Analysis System otherwise known as QMAS came in. The purpose of QMAS was to collate QOF data and run practice system updates three times a year and provide feedback to practices about their performance against national QOF targets upon which payments were based. The NHS Connecting for Health website boldly states that QMAS allows for practices to be paid ‘according to the quality of care they provide’. This suggests that high QOF scores are viewed as being synonymous with quality care, a concept that will be questioned later on in this chapter.²

Such a complex system needed to be fully functional during its first year to avoid payment failures for GPs and it was perhaps risky to launch a computerised quality scoring structure which was simultaneously linked to payments in the first year of QOF. Had QMAS not translated quality points into payment accurately, QOF would have no doubt been rejected by GPs as an ineffective P4P scheme, resulting in a sizeable challenge to engage practices with the initiative beyond year one. In the year following QOF’s inception, GPs were consistently paid in line with the new GMS Contract rules. The integration of QMAS into primary care was hailed a success.

A further information technology response following the introduction of QOF was the adaptation of in-practice systems and electronic patient records to allow for QMAS compatibility and more sensitive READ code searches year on year. The resulting software now provides prompts for clinicians to gather QOF related data during a consultation and has helped to endorse the use of electronic templates for this purpose. It appears that this more methodical approach to patient consultations has been accepted by general practitioners and other primary care professionals.³

This improved infrastructure for primary care informatics led to the creation of the largest national primary care database in the world. A discussion of the value and drawbacks of this in relation to research follows.

QOF and research

Publicly available QOF data have provided researchers with a wealth of information at their fingertips. Prior to QOF, researchers relied on the goodwill of an often limited group of practices open to taking part in research studies and as a result were faced with problems of selection bias and participant fatigue. However the use of QOF informatics as a research tool does have some drawbacks.

One limitation concerns the at times blurred distinction between audit and original research.

Using routinely collated service audit data in research requires a thorough consideration of consent and confidentiality issues. QOF was designed solely for the purpose of monitoring care and identifying opportunities for service improvement by focusing financial incentives in a particular domain. As QOF data are gathered purely for payment purposes, information about practice performance which is not linked to GMS contract financial rewards is omitted from the scheme. Researchers hoping to study GP consultation and diagnostic skills for instance will clearly have to look for data beyond those available through QOF.

But it is not just qualitative data that are lacking, which is perhaps expected from a tool intended to *measure* performance. For instance QOF informatics does not provide information about patient demographics such as sex and age within particular chronic disease groups. QOF data are presented in a way which does not allow for the modelling of relationships between the indicators across chronic disease domains, apart from smoking status and advice which can be viewed across all disease categories. The lack of a cross-tabulation function does not allow for chronic disease multimorbidity searching. One person who may have something to say about this is the patient who is called in for numerous reviews towards the end of the tax year, instead of a single coordinated person-centred consultation. Naturally this issue does go beyond QOF limitations in research use and has implications for public health disease prevalence studies.

A further point concerns the research validity of QOF data. The prevalence of each of the 19 chronic diseases currently included in the QOF is not independently verified. There is some evidence for instance of QOF coronary heart disease underreporting as compared to self-reported census rates.⁴ As such, a practice may simply have lacked vigour and effective organisation in building up their disease registers. Patients who, for one reason or another, have not been coded or been incorrectly coded will not be on the disease register. The practice of exception reporting which will be explored later, may exclude certain patients from the research sample again leading to selection bias.

This brings to light another important implication for the usefulness of QOF informatics in representing practice performance - evidently there is an association between data recording approaches and practice performance on the QOF. This poses a question as to whether high QOF performance merely represents the data recording skills of a practice, rather than the levels of care quality it offers.

Better care or better recorded care?

Practices with more highly developed management infrastructures and a shared ethos of coding every possible QOF related activity will inevitably have higher QOF scores at the end of the accounting year. Many apparent improvements in care amount to little more than increased conscientious coding. For example, a practice failing to reach the 90% target for retinopathy screening in diabetes (DM21) may find that this target is achievable simply by searching through scanned correspondence from the hospital diabetic clinic or local optometrist reporting retinopathy findings.

In some senses, the practice may be making economic decisions based on workload, time and the type of professional needed to reach the target. On this basis, a practice may make one of three decisions. It may decide that it is not cost effective to chase the final QOF point (DM 21

is worth 5 points for achieving 90% target) and remain below the top target. Or it may invest in additional data input staff to find and code missing clinical data. Or, and most expensively, it may invest in additional medical personnel to examine, say, an additional ten diabetic patients in order to gain all five available QOF points.

Better recording undoubtedly results in higher QOF points but arguably, may not represent better care. Equally, low scoring practices may be less skilled at handling large data volumes and not necessarily be providing poorer care. It is possible that low scoring practices display other domains of excellence not captured by QOF, such as continuity of care, patient-centred consultation skills, diagnostic skills and the care of illnesses not included in the QOF. It is the pragmatic organisational decisions of general practices, based on perceptions of workload and money, that have resulted in some commentators describing QOF not so much as a pay-for-performance system, but a 'pay-for-reporting' system.⁵ This clear link between methods for data recording and QOF performance, coupled with financial incentives for achieving high QOF scores may render the scheme vulnerable to data manipulation or gaming.

Gaming and P4P

Within the political context of value for money and quality improvement as the main driving force behind health policy development, the QOF P4P system was seen both as a means to make primary care more accountable to the public and a tool to incentivise improved quality of care. However the introduction of financial incentives into healthcare has led to concerns about the potential for P4P to motivate healthcare professionals to manipulate data in order to increase QOF scores and therefore financial rewards.⁶ Moreover the public availability of QOF data may lead to stigma resulting from scoring poorly on the QOF and inevitably produce a means of ranking of general practices. It has been argued that gaming behaviours are further motivated by attempts to avoid such stigma.⁷

Hood⁸ describes three types of gaming presented in the table below with possible QOF applications:

Table 1: Types of gaming and QOF opportunities.

Type of gaming	Definition	QOF opportunities
<i>Threshold Effect</i>	Reduction of performance to just what the target requires	Practices will still be rewarded financially for working to a certain percentage of the target, rather than meeting it for 100% of patients on a given register Exception reporting so as to reduce workload
<i>Ratchet Effect</i>	Underperformance to prevent target increase	Targets are set nationally and underperformance in single practices is unlikely to influence the level at which a target is set
<i>Output Distortion</i>	Intentional manipulation of reported results	A spectrum running from selecting indicators for data entry which fit the target best, through to QOF fraud

The subject of gaming and manipulation of target achievement is controversial. Gaming is not unique to QOF and is probably a feature of all P4P systems. The National Audit Office report on the 2004 new contract for GPs suggested that QOF income could be inappropriately boosted by deliberately removing patients for whom GPs may perhaps miss QOF targets from disease registers or by increasing levels of exception reporting.⁹ In this vein it has been suggested that exception reporting although high in only a small proportion of practices, is the strongest predictor of practice achievement on the QOF.¹⁰ There may well be more kudos to achieving high QOF scores for a small number of patients, than in gaining average scores across a larger chronic disease register.

On the other hand QOF provides financial incentives for increasing the number of patients recorded on a disease register, as QMAS adjusts payments on the basis of disease prevalence. This may encourage the inclusion of patients with clinical measures on the cusp of diagnostic criteria on a particular chronic disease register. Here gaming has direct implications for the quality of patient care, since it may put patients at risk of unnecessary disease monitoring and possibly unsuitable treatment interventions.

Gaming may well generate overlarge financial rewards in just a few practices. But how widespread a phenomenon is it? Some have suggested that gaming is endemic but a more balanced perspective emerged from the Centre of Health Economics which concluded that practices could have treated 12.5% fewer patients without falling below upper QOF thresholds.¹¹ This suggests that GPs have not taken the opportunity to produce a threshold gaming effect, whereby the quantity and quality of work can be reduced to the minimum needed to meet the target. In other words, GP practices had overshot targets to a much larger extent than the likely level of exception reporting. Indeed figure 1 shows a decrease in exception reporting nationally, across the last four years of QOF data (exception reporting rates were not available through QMAS for the year 2004/05):

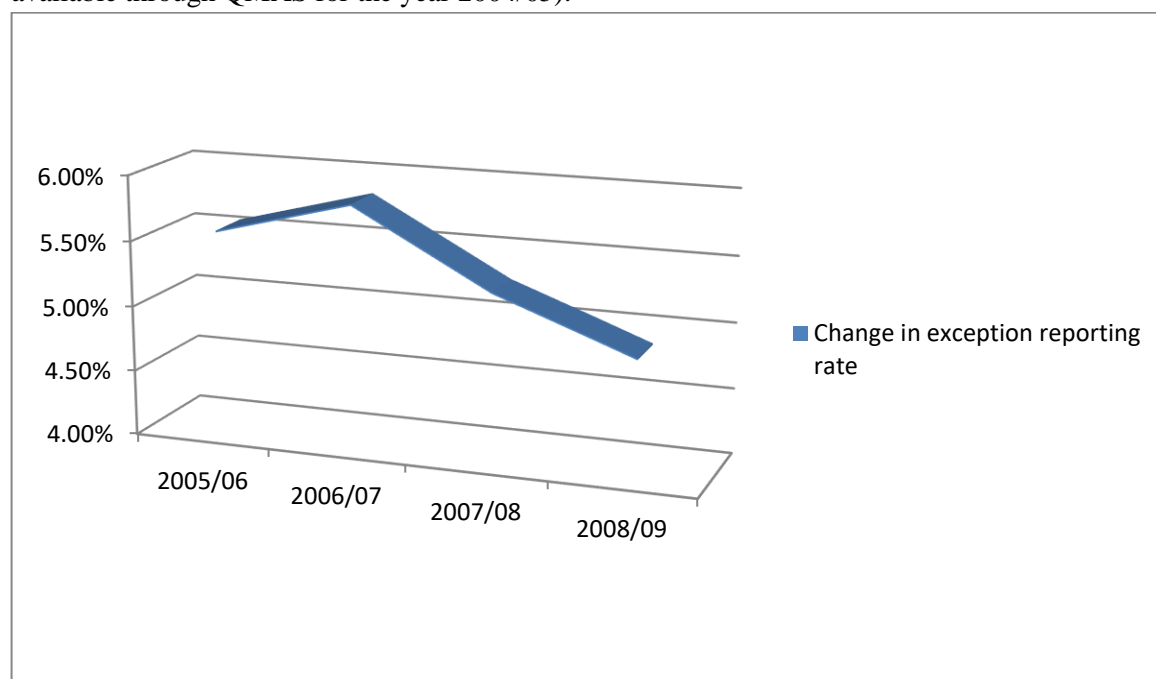


Figure 1: National QOF exception reporting rates.

Nonetheless one of the challenges of QOF has been how to tackle the potential for gaming which is inherent in any P4P scheme. Although all general practices are given an inspection-type visit annually by representatives from the Primary Care Trust, these may be insufficient to detect evidence at case level of inappropriate exception reporting or exclusion from disease register. Although inspection guidance makes a distinction between data manipulation due to error and by intention¹², subtleties of the different levels of gaming may not be picked up and there is potential for errors to be labelled as QOF fraud.

Inconsistencies in data entry between and within practices may be influenced by the lack of clear guidance around the methods for measuring and recording indicators, rather than fraudulent activity linked to financial motivations. For instance a blood pressure reading on a patient's electronic notes may be the 'best' of three measurements taken in a consultation, the average of readings taken on separate occasions or even the reading that is closest to the target entered electronically from paper notes by the practice administrator. This is further compounded by the fact that target levels recommended by the GMS contract differ from those promoted by NICE and the British Hypertension Society. This has led some commentators to state that defining QOF targets without clear guidance is 'largely meaningless'¹³. Therefore what can appear to be fraudulent data recording may simply be the result of clustering due to unclear methodological guidance. It is unlikely that P4P will ever produce normally distributed epidemiological data, yet PCT assessors are advised to investigate clustering which appears not to be the result of 'energetic treatment'.¹²

The notion of the healthcare professional gaming data in order to achieve financial gain is likely to be an oversimplification. A number of studies have shown that unless external incentives such as payments for performance appeal to the professional values of the individual concerned, they paradoxically reduce performance¹⁴. Professionalism is one driver of quality which is in danger of being ignored by QOF. And yet it is a sense of professionalism, the accumulation of a body of specialist knowledge and wisdom placed at the service of society, and a public service ethos which probably motivate GPs more in the long term than a financially driven P4P system. It is hard to see how any P4P system could reward the components of professionalism, as expounded by Downie.¹⁵

However there can be no doubt that debates concerning gaming behaviours in general practice do not hold the same significance for patient care as the key question of whether or not QOF and QOF informatics have led to tangible improvements in the nation's health.

Illusory public health gains?

There can be no doubt about the concrete improvements since QOF was instituted in terms of overall quality improvement and gains in 'intermediate outcomes' such as blood pressure and cholesterol control. However, the successes of QOF have been tempered by concerns that some of the achievements captured through informatics might not be as substantial as they appear to be.

The quality of primary care proved to be far higher than was expected at the time QOF was introduced. The Department of Health based pay calculations on an expected QOF score of 750

at the end of the first year (2004/5). In fact, the 8600 practices of England had a mean QOF score of 958.7 (out of a maximum possible score of 1050 points) which represented 91.3% of available points.¹ Two hundred and twenty two (2.6%) of these practices achieved the maximum score. In spite of several annual revisions to the QOF, revising targets upwards and adding indicators, the 2008/9 mean QOF score achievement was 954.2 of available points (the maximum is currently 1000 points) with 2.0% of practices achieving the maximum score.¹

The graph below shows the change in QOF scores nationally since QOF's introduction in 2004:

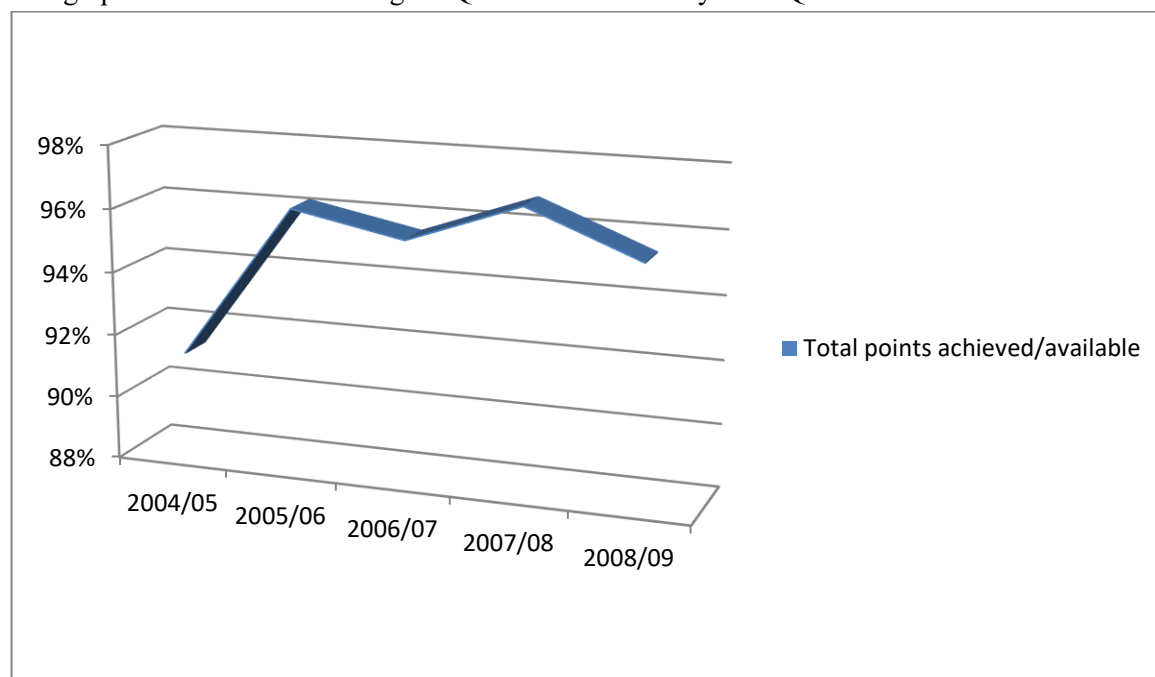


Figure 2: QOF scores nationally 2004-2009 as a percentage of total points achieved out of the total available.

These scoring gains have also translated into public health gains, albeit on a rather piecemeal basis. In an evaluation of QOF in its original incarnation, Fleetcroft *et al* however concluded that there was 'no relationship between pay and health gain', at least for the eight public health and preventative interventions which were included in their study.¹⁶ This is perhaps unsurprising because the level of P4P financial reward was based on estimates of likely GP workload rather than on health gain for patients. However, if QOF continues to be generously funded, it has to be able to demonstrate that it is money well spent and that the opportunity costs of tying up health care funding in QOF are considerable.

The weighting of QOF points, since they reflect a pay deal for GPs, continues to be driven by the assumed workload attached to achieving each indicator and not the likely benefit to patients. Thus, for example, the indicator DM23 (50% achievement of an HbA1c target for diabetics of 7.0 or less) is awarded 17 points whereas DM18 (influenza vaccination target of 85% for diabetics) merely attracts 3 points. Moreover, many of the public health indicators within QOF such as blood pressure, cholesterol and HbA1c control were improving before the arrival of QOF. Nevertheless, there has been evidence of public health gain with substantial improvements in, for instance, the management of diabetes and control of cardiovascular risk factors in diabetic patients.¹⁷

A further public health success has been the drive to reduce health inequalities. The differences in QOF achievement between deprived and prosperous areas have been small and, over time, there is evidence that these differences have diminished.¹⁸ The narrowing of target differences between rich and poor communities has been part of an overall trend of improved performance with somewhat greater improvements seen in more deprived communities.¹⁹

One reason for questioning the success of P4P in its incarnation as QOF is that three technical features of QOF may have diminished the reach of performance targets.

Firstly, the process of 'exception reporting' necessarily allows certain patients, deemed 'unsuitable', to be excluded from the overall target for patients registered at the practice. Patients may understandably be excluded if they are terminally ill or if they do not agree (after three written requests) to attend an appointment at the surgery for the management of their chronic disease. This suggests that non-attenders will be further excluded from drives to engage patients in public health improvement initiatives. They will therefore be invisible to QOF targets and the public health effectiveness of population targets will be reduced. The overall exception reporting rate for 2008/9 was 6.88% for indicators measuring an outcome and 1.70% for indicators measuring a process. So, on average, almost 7% of patients in England are excluded from public health targets such as achievement of a serum cholesterol of <5mmol/L.

Secondly, the targets are not set at 100%. Again this is understandable given the practical difficulties of achieving clinical targets. These targets are rarely achieved in research trial conditions, let alone in routine practice, even with often large financial incentives to spur on the team. However, targets set at 70% for blood pressure control or cholesterol control in coronary heart disease (CHD6 and CHD8) further exclude 30% of patients from these public health targets. Thus in combination with exception reporting, targets set below 100% may shift the focus of the practice away from harder to reach patients, in exchange for more efficient achievement of results.

The success of QOF may be tempered in other respects. Performance may have improved in domains covered by performance indicators but remain static in areas out of the spotlight, such as a rheumatological and gastrointestinal disease. Increasingly, the proposals for strengthening QOF are focussing on aligning the indicators and the associated QOF points with public health gains. Now that NICE has taken overall responsibility for QOF development, the expectation is that QOF will develop along the lines of NICE guidelines and favour cost-effective public health interventions where one of the costs to be considered may well be the cost of QOF points themselves. Yet, there are suggestions that performance has now reached a ceiling and that other approaches are needed to coax further improvements out of primary care.

Another potential approach to quality improvement could be greater inclusion of feedback from patients in the overall spread of P4P indicators. Prior to 2008/9, GPs simply gave out questionnaires to a selection of patients and 'patient experience' points were awarded on the basis of completed surveys and reflection on the results of these surveys. Since then, a more rigorous approach has been adopted with independent patient surveys conducted by polling organisations. GPs are now rewarded on the basis of responses to two questions about time taken to access an appropriate health professional (PE7 and PE8). The questions asked have

been criticised as being politically driven and not representative of patients' needs; they do not ask about the consultation or perceived standards of care. One danger of this approach is the unintended consequence of less satisfied responses from patients in deprived communities which may result in more funding being directed toward practices serving populations with lower health care needs. Yet the inclusion of these indicators does mark the introduction of a certain sense of capturing the patient 'voice' within QOF informatics, albeit perhaps on a rather tokenistic level at this stage.

Conclusion

So is QOF all smoke and mirrors, or has it produced informatics opportunities which outweigh its limitations? There is no doubt that QOF has brought with it a coherent wealth of primary care data that was unobtainable prior to its inception. Data used to provide performance monitoring information for general practices can be set against targets determined by the GMS Contract and are now widely available. So too is information that contributes to identifying potential public health inequalities. However the key lies in recognising the limits of how QOF informatics can be used. Bold statements about QOF's power to raise and sustain the quality of patient care ignore the subtleties of gaming behaviours in the face of financial rewards.

In addition informatics sourced from QOF represents only a snapshot of the day-to-day work of general practices in England. The underlying essence of good primary care lies in subjective notions of rapport, interpersonal skills, compassion and professionalism to name but a few and therefore is unlikely ever to be fully captured through pay for performance initiatives. QOF informatics may therefore have illusory effects that detract from grounding quality improvement in the reality of patient experience. Nonetheless when all is said and done, QOF has emerged as one part of a multifaceted approach to raise quality standards in primary care. It has its imperfections and flaws. Like all incentive schemes, it is prone to the law of unintended consequences. Yet overall, the practical application of QOF throughout UK primary care has risen above the shortcomings, and it has contributed to the drive to embed high quality care in routine practice.

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C. Research governance: assailing a paper mountain

Here is a personal view of the rigmarole I have been experiencing as a PhD student applying for local Research and Development (R&D) approval to conduct my relatively low-risk study. The very mention of ‘ethics’ and ‘R&D’ elicits sighs all round from the PhD office and this is not without good reason. I, for one, have found the application system complex, inconsistent and at times, rather discouraging.

Since 2008, an online Integrated Research Application System (IRAS) has been in operation for the purpose of seeking ethical approval nationally and facilitating local research governance approval. The creation of IRAS followed a Department of Health advisory group report calling for a streamlined ethics application system (1). My first challenge on embarking on this supposedly simpler process was navigating my way around the National Research Ethics Service (NRES) website and its obvious penchant for acronyms.

Once I knew my CAS from my SSA, I faced the 70-question ethics form. The nature of my research (a qualitative organisational study of low QOF scoring general practices) placed it at odds with the hypothetico-deductive format the form takes. Yet despite it being difficult to specify exactly what my exploratory research might involve from the outset, and finding the form inflexible at times, it rightly prompted me to reflect on the ethical implications of my work. Finding that local ethics committees were fully booked for a number of months ahead, I travelled 60 miles to attend the next available meeting. The experience of this meeting was very encouraging and I found the panel supportive. Approval without amendments was granted swiftly. So far, so good.

But my excitement about starting fieldwork soon after was, in retrospect, rather naïve. NRES advises that researchers do not wait for ethical clearance to be approved before seeking local research governance approval through PCT R&D offices. However, the R&D requirement to identify a local collaborator at the GP practice research sites I would be visiting, left me in a chicken or egg predicament. Approaching GPs at this stage in the case of my study was synonymous with participant recruitment prior to gaining ethical approval to do so. Additionally, I felt that the label ‘local collaborator’ may hold burdensome connotations for GPs, whom it was already hard enough to persuade to take part in my project as research participants.

At the time of writing I had applied to three PCT R&D offices. There was nothing ‘integrated’ about this experience. Each office required at least 10 different documents to be emailed through, in a variety of formats (pdf, xml, three large envelopes filled with old-fashioned paper). I was also asked to provide documentation which was not listed on the checklist, such as a financial breakdown of study funding arrangements. Some emails bounced back due to attachment size. At this point I was climbing a mountain of paperwork, which might have honed my administrative skills, but did little for my academic development as a postgraduate researcher. One could say that I was on the receiving end of what Haggerty (2) coined the ‘ethics creep’. The unique skills required for negotiating the ethical complexities of researching health services were being substituted by cumbersome bureaucracy.

Yet, most importantly, I believe that the research governance process lacks the transparency of the national ethical review. Information about who makes the decision about R&D approval is not made available to the researcher, and it is unclear on what grounds a decision is reached. Indeed, I have been faced with an unfavourable decision which I believe is not consistent with the checks stipulated in the Research Governance Framework for Health and Social Care (3). As justification, I was provided with an inaccurate statement of my study aims to support the decision of the office in question. There was no mention whether I could appeal.

My experience is not atypical and raises issues such as the lack of research governance consistency and transparency. There is a clear requirement for a greater balance in addressing the needs of the research process, as well as of those being researched. Impeding health services research through excessive bureaucracy cannot be in the public interest. Just one suggestion for improving the IRAS online system would be an integrated function for uploading attachments and thus submitting the same documents to all R&D offices at the push of a button. At a time of financial austerity, this would no doubt be a time-saving and therefore cost-cutting solution. Furthermore, the composition of the panel behind the R&D decision and the criteria they use for evaluating applications should be made explicit to the researcher. Behind such changes should lie the ultimate goal of removing the frustrating bureaucratic burden faced by health service researchers, while endeavouring to maintain the highest ethical standards throughout the research process.

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D. Identifying poorly performing general practices in England: a longitudinal study using data from the Quality and Outcomes Framework

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Objective: To determine the characteristics of general practices which perform poorly in terms of Quality and Outcome (QOF) performance indicators in England's NHS.

Method: Retrospective, four year longitudinal study, 2005 to 2008. Data were obtained from 8515 practices (99% of practices in England) in year 1, 8264 (98%) in year 2, 8192 (98%) in year 3 and 8256 (99%) in year 4. Outcome measures: QOF performance scores; social deprivation (IMD-2007) and ethnicity from the 2001 national census; general practice characteristics.

Results: We identified a cohort of 212 (2.7%) practices which remained in the lowest decile for total QOF scores in the four years following the introduction of the QOF. A total of 705,386 patients were registered at these practices in year 4. These practices were more likely to be singlehanded (odds ratio [OR], 13.8), nontraining practices (OR, 3.9) and located in deprived areas (OR, 2.6; most vs least deprived quintiles). General practitioners (GPs) in these practices were more often aged ≥ 65 years or more (OR, 7.3; mean GP age ≥ 65 years vs <45 years), male (OR 2.0), UK qualified (OR 2.0) with small list sizes (OR 3.2; list size <1000 vs 1500–2000 patients). We identified individual QOF indicators which were poorly achieved. The reported prevalence of most chronic diseases was lower in the poorly performing cohort.

Conclusions: A small minority of practices have remained poor performers in terms of measurable performance indicators over a four-year period. The strongest predictors of poor QOF performance were singlehanded and small practices, and practices staffed by elderly GPs.

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Introduction

In parallel with the increased adoption of performance indicators in health-care systems, there has been an expanding literature describing their role as incentives in pay-for-performance systems, for driving up overall quality standards and for justifying public investment in health.¹ The Quality and Outcomes Framework (QOF), introduced in England in 2004, has been acclaimed in terms of demonstrating pre-existent levels of high quality primary care, overall quality improvement and the reduction of health inequalities.¹ Dissenting voices have raised concerns about 'tick-box medicine', the failure to value personal care and the lack of validated indicators measuring many of the essential functions of primary care such as early diagnosis and empathic care.² Some chronic diseases have been omitted altogether from the indicators used.

Evaluation of health-care systems in terms of performance indicators has generally focused on overall achievement rather than the poor performance of a few. This makes sense from a public health perspective since the population is better served by concentrating on raising the mean standard rather than concentrating on improving the performance of the outliers. General practice though, is different. With its registered list system, UK general practice offers patients

exclusive registration at one practice. If that practice is poorly performing, each of the patients registered at the practice lacks alternative access to higher quality primary care, short of registering with another practice. Most patients form a long term relationship with their practice and their own general practitioner (GP) which acts as a disincentive to change practices in search of higher quality standards.

Although concerns have been raised about poor performance in individual practitioners and about wide variations in performance, none of the international literature about performance indicators has described the characteristics of general practices which continue to perform poorly over time. We decided to use the performance data contained within the QOF to identify the characteristics of sustained poor performance among general practices, during the four years for which QOF data are currently available.

Methods

QOF data

We obtained QOF data covering the four years April 2004 to March 2008 for all general practices in England. These data covered the following domains: chronic disease management; practice organization; patient experience; additional services; and access.

Practice and population characteristics A detailed national summary of practice characteristics was obtained.³ Variables included: practice list size; age/sex breakdown of registered population; number of full time equivalent GPs; the age of the GP; the country where each GP was medically qualified; and training practice status. A variable was constructed to describe the mean age of GPs in each practice. We took the mid-point of each of the ten age categories in the original data and used this to determine a weighted average for the practice as a whole, based on the number of full time equivalent GPs in that category. This value was then used to allocate each practice into one of four mean GP age categories: under 45 years; 45–54 years; 55–64 years; and ≥65 years. Data from the 2001 national UK Census were obtained based on the Lower Layer Super Output Area (SOA)⁴ for each practice and used as the basis for calculating social deprivation (the Index of Multiple Deprivation, or IMD-2007⁵) and ethnicity. Each SOA consists of about 1500 people within a defined geographical locality. Census data based on the home address of all patients registered at a general practice are not available in England so the SOA in which the general practice was located had to act as a proxy for the registered population at each practice.

Statistical methods

We constructed a dataset containing QOF data, practice and SOA-based census variables for all practices in England. We removed practices from the dataset if they were no longer independent at the end of the study year or had a list size of under 750 patients or under 500 per full time equivalent GP on the grounds that these were likely to be newly formed or about to be closed. We defined longitudinal cohorts of poorly performing practices based on their total QOF score over each of the four years for which QOF data are available. We then explored the characteristics of these poorly performing practices using univariate analysis (simple logistic regression) to define their practice and demographic characteristics. We then searched

Table 1 Cohorts of practice performance over four consecutive years 2004–2008

Performance cohort	Number of practices (%)	Mean QOF score, year 1*	Mean QOF score, year 2*	Mean QOF score, year 3	Mean QOF score, year 4
Practices in lowest 5% in each year	<i>n</i> = 64 (0.8%)	550.5	698.1	665.4	733.6
Practices in lowest 10% in each year	<i>n</i> = 212 (2.7%)	645.8	777.0	745.8	804.2
Practices in lowest 15% in each year	<i>n</i> = 348 (4.4%)	690.6	812.6	779.4	835.3
Practices in lowest 20% in each year	<i>n</i> = 542 (6.8%)	727.3	840.4	808.6	862.1
Practices in lowest 25% in each year	<i>n</i> = 753 (9.4%)	755.5	860.5	833.6	881.0
All practices	<i>n</i> = 7,984	919.9	965.7	958.5	969.3

*Value excludes 50 QOF points for 'Access' which were only available in years 1 and 2. The maximum QOF score described for all four years is therefore 1000 points. QOF = Quality and Outcomes Framework

for possible confounding variables using multivariate analysis (multiple logistic regression). The analyses were conducted using logistic regression which produces odds ratios (ORs) for the likelihood of being a poorly performing practice. Logistic regression requires a reference variable to be defined amongst the range of each ordinal variable. The ORs represent the likelihood of belonging to the poor performers' cohort compared to the reference group. Values .1.0 mean that these practices were more likely to be in the poorly performing cohort than practices in the reference group.

Results

Practices included in the analysis Sixty-one practices were removed as likely to be newly formed or about to be closed in year 1, 145 in year 2, 180 in year 3 and 38 in year 4. Due to postcode and SOA anomalies, we were unable to match IMD-2004 and ethnicity data for 35 practices in year 1, none in year 2, 361 in year 3 and 1 in year 4. The final dataset consisted of 8515 practices (99% of the total) in year 1, 8264 (98% of the total) in year 2, 8192 (98% of the total) in year 3 and 8256 (99% of the total) in year 4; data were available for 7984 practices in all four years of the study.

Defining poorly performing practices

Overall, 212 (3%) practices remained in the cohort of practices with QOF scores in the lowest 10% during each of the four consecutive years of the study, 542 (7%) remained in the lowest 20% cohort and 753 (9%) in the lowest 25% cohort (Table 1). Rising national mean performances in all practices over the four-year period of study were mirrored by rising mean values in each of the poorly performing cohorts (Table 1).

In order to focus on the poor performers, our principal analysis was based on the 212 practices remaining in the lowest 10% for total QOF scores during the first four years after the introduction of the QOF (the 'poor performance cohort'). A more stringent definition of poor performance would have reduced the significance of the analysis; a more generous definition would have substantially increased the number of practices in the poor performance category, thus reducing face validity. The mean QOF score of the poorly performing cohort was 804 in year 4; the mean score for the remaining practices was 976. A total of 705,386 patients were registered at these practices in the final year of study.

Practices omitted from the analysis

The total number of general practices in England has declined since 2005. To ensure that we

had not missed poor QOF performance in their final year before closure, we explored mean QOF performance in these practices. Practices which closed in the subsequent year did have lower QOF performance than national mean levels, but their overall QOF performance was significantly higher than practices in the poor performance cohort (Table 2).

Characteristics of the poorly performing practices – univariate analysis

The characteristics of the 212 ‘poorly performing’ practices are summarized in Table 3. Characteristics strongly associated with poor performance were non-training practices and practices with older GPs. Practices with large list sizes per full time equivalent (FTE) GP were not more likely to be in the poorly performing cohort.

Characteristics of the poorly performing practices – multivariate analysis

Multivariate analysis was conducted using the poorly performing cohort of 212 practices as the dependent variable. All of the variables explored using univariate analysis were included in the multivariate analysis (Table 4). Some variables were no longer significant in the multivariate analysis and some variables changed their direction of association. The ethnicity of the local population no longer remained a significant predictor, mainly because ethnicity was strongly confounded by social deprivation. Similarly, non-UK trained GPs initially appeared more likely to be poor performers, but once adjusted for confounding, particularly by singlehanded status and GP age, the association with poor performance was stronger for UK trained GPs. Based on the findings of the multivariate analysis, the strongest predictors of poor performance were singlehanded status, mean age of GPs and training practice status (Table 4). Smaller practices in general were more likely to be poor performers: the OR was highest for singlehanded practices at 13.87 (compared to practices with .4 FTE GPs) and fell progressively as practice size increased. Similarly, practices with older GPs were more likely to be poor performers: the ORs rose progressively in the three older age bands, reaching 7.32 for practices where the mean age of GPs was 65 years or more, when compared with practices where the mean age was under 45 years. Non-training practices were more likely to be poor performers: OR 3.90.

Table 2 QOF performance of practices which closed in the years 2004–2008 compared with QOF performance of poorly performing practices in the same year

Final year before practice closure	Practices which closed: mean QOF score in final year	Practices in poor performance cohort: mean QOF score (n = 212)	Significance of difference
QOF Year 1 (2004/05)	733.9 (n = 284)	645.8	t = 4.94; P < 0.001
QOF Year 2 (2005/06)	876.3 (n = 165)	777.0	t = 7.75; P < 0.001
QOF Year 3 (2006/07)	854.0 (n = 97)	745.8	t = 6.74; P < 0.001

QOF = Quality and Outcomes Framework

Table 3 Relationship between poor performance and descriptive primary care variables: simple logistic regression.

Variable	Proportion in poor performance cohort (%)	Proportion in national sample (%)	OR (95% CI)*	P value
<i>Full time equivalent (FTE) GPs</i>				
≤1	56.9	18.7	32.12 (15.65–65.91)	<0.001
>1 and ≤2	24.9	17.8	13.70 (6.49–28.92)	<0.001
>2 and ≤3	11.0	14.5	7.16 (3.19–16.06)	<0.001
>3 and ≤4	3.3	13.9	2.24 (0.81–6.20)	0.12
>4	3.8	35.1	–	–
Non-training practice	97.6	72.5	16.45 (6.77–39.99)	<0.001
<i>List size per FTE GP</i>				
<1000	3.3	2.1	3.24 (1.44–7.27)	<0.001
1000 to <1500	23.0	20.8	2.01 (1.35–3.01)	<0.001
1500 to <2000	23.4	42.3	–	–
2000 to <2500	30.6	21.1	2.70 (1.85–3.93)	<0.001
2500 to <3000	12.4	7.5	3.12 (1.92–5.06)	<0.001
3000 to <3500	2.4	3.1	1.45 (0.57–3.68)	0.43
≥3500	4.8	3.1	2.94 (1.47–5.88)	<0.001
<i>IMD–2007 quintiles</i>				
most deprived	35.4	20.0	4.27 (2.57–7.11)	<0.001
2nd most deprived	25.5	20.0	2.94 (1.73–4.98)	<0.001
3rd most deprived	17.9	20.0	2.05 (1.18–3.57)	0.01
4th most deprived	12.3	20.0	1.37 (0.76–2.49)	0.30
least deprived	9.0	20.0	–	–
<i>GP age (mean for practice, in years)</i>				
<45	7.7	30.1	–	–
45–54	29.7	47.3	2.49 (1.43–4.32)	<0.001
55–64	40.7	18.3	9.31 (5.43–15.94)	<0.001
≥65	22.0	5.2	26.54 (14.81–47.55)	<0.001
GP gender (male)	80.2	65.0	12.04 (6.57–22.04)	<0.001
GP place of medical qualification (UK)	45.8	67.7	0.27 (0.19–0.37)	<0.001
Area ethnicity (non-white)	20.1	12.5	5.50 (3.17–9.55)	<0.001

OR = odds ratio; GPs = general practitioners; CI = confidence interval

Singlehanded status and variability In any study of the characteristics of general practices, singlehanders may be disproportionally represented among the outliers. This is because variations in the performance of individual GPs may be cancelled out within a group practice. To determine if the association of poor performance with singlehanded status was the result of a statistical artefact, we calculated the variability of QOF scores in singlehanded and group practices. The standard deviation of total QOF score was 86.0 in singlehanded practices, 55.3 in practices with 1.1–2 FTE GPs, 47.6 with 2.1–3 FTE GPs, 32.0 with 3.1–4 FTE GPs and 24.5 with over 4 FTE GPs. Having established the greater variability in total QOF score among singlehanders, we determined whether singlehanded status was more strongly associated with poor performance or with high performance. We created a cohort of high performing practices by selecting those with total QOF scores in the top 10% for each of the four years of our study ($n = 183$). Based on the same method as above, the adjusted OR for singlehanded practices belonging to the high performing cohort was 1.41 (95% confidence interval [CI], 0.64 to 3.09; $P = 0.40$).

Singlehanded practices were thus more likely to have a total QOF score scattered across a wider range than group practices, were significantly more likely to be in the poor performance cohort of practices, but not significantly more likely to be in the high performance cohort. Although 56% of our sample of poor performers were singlehanded, this represents just 8% of all singlehanders.

Table 4 Relationship between poor performance and descriptive primary care variables: multiple logistic regression

Variable	OR (95% CI)*	P value
<i>Full Time Equivalent (FTE) GPs</i>		
≤1	13.87 (6.03, 31.87)	<0.001
>1 and ≤2	5.97 (2.66, 13.39)	<0.001
>2 and ≤3	4.25 (1.83, 9.84)	<0.001
>3 and ≤4	1.61 (0.57, 4.52)	0.36
>4	—	—
Non-training practice	3.90 (1.52, 10.01)	<0.001
<i>List size per FTE GP</i>		
<1000	3.22 (1.37, 7.56)	0.01
1000 to <1500	2.94 (1.91, 4.51)	<0.001
1500 to <2000	—	—
2000 to <2500	1.30 (0.87, 1.93)	0.20
2500 to <3000	0.94 (0.57, 1.57)	0.82
3000 to <3500	0.31 (0.12, 0.80)	0.02
≥3500	0.67 (0.32, 1.38)	0.27
<i>IMD-2007 quintiles</i>		
most deprived	2.59 (1.50, 4.47)	0.00
2nd most deprived	2.02 (1.15, 3.55)	0.01
3rd most deprived	1.45 (0.81, 2.60)	0.21
4th most deprived	1.23 (0.67, 2.29)	0.50
least deprived	—	—
<i>GP age (mean for practice, in years)</i>		
<45	—	—
45–54	1.79 (1.02, 3.15)	0.04
55–64	2.94 (1.59, 5.43)	<0.001
≥65	7.32 (3.68, 14.58)	<0.001
GP gender (male)	2.03 (1.24, 3.33)	<0.001
GP place of medical qualification (UK)	1.95 (1.33, 2.85)	<0.001

OR = odds ratio; CI = confidence interval; GPs = general practitioners

Poor performance and geographical distribution

The 212 practices in the poor performance cohort were distributed unevenly throughout the country. Of the ten strategic health authorities (SHAs) in England, those with the highest proportion of practices in the poor performance cohort were London SHA at 4% (n = 57), south east coast SHA at 3% (n = 21) and West Midlands SHA at 3% (n = 32). In contrast, less than 1% of practices were in the poor performance cohort in two SHAs: south central, 0.2% (n = 1) and north east, 1% (n = 4).

Poor performance, QOF domains and QOF indicators

The poor performance cohort was defined in terms of its total QOF score. But is achievement diminished equally across all domains and all indicators within the QOF? The profile of QOF performance in the poorly performing cohort is summarized in Table 5. Particular shortfalls in clinical indicator categories in the poorly performing cohort were achievements on the depression, mental health and palliative care categories. Notable shortfalls in the achievement of individual QOF indicators were those related to mental health (five out of the nine clinical indicators with the greatest shortfall were depression or mental health indicators) and those related to poor record keeping (five out of the six organizational indicators with the greatest shortfall referred to records of clinical summaries or repeat prescribing).

Table 5 QOF performance: achievement of QOF categories and individual indicators in poorly performing practices

QOF disease category	Achievement (%) ^a in poorly performing cohort	Achievement (%) ^a in remainder of practices	Difference (%) ^b
Depression	46.2	92.5	50.0
Mental health	70.0	95.0	26.4
Palliative care	71.5	93.3	23.4
Cancer	76.7	97.1	21.0
COPD	77.9	98.3	20.9
Epilepsy	75.4	95.3	20.8
Dementia	79.3	98.4	19.4
Asthma	79.9	98.4	18.8
Heart failure	82.7	98.7	16.2
Atrial fibrillation	87.0	99.1	12.2
CKD	85.8	97.5	11.9
Stroke	87.4	98.8	11.6
Diabetes	87.5	98.5	11.1
CHD	90.6	99.3	8.8
Learning disability	91.5	99.2	7.8
Blood pressure	91.6	99.2	7.7
Smoking	92.5	99.3	6.8

Overall, the poor performance cohort was characterized by poorer organizational domain scores than clinical indicator scores. Poorly performing practices scored a mean of 71% (95% CI, 69–74%) of available organizational domain QOF points and 84% (82–85%) of clinical QOF points. In contrast, the remaining practices had similar organizational and clinical indicator scores, achieving 95% (95–96%) and 98% (98.0–98.2%), respectively. Differences between the poor performance cohort and the remaining practices might have been distorted by differential exception reporting rates.⁶ Differences are known to occur in the willingness of practices to exception report certain patients, thus excluding them from performance targets. Exception report rates can only be calculated for those clinical indicators which apply to the whole disease register. Where available, values corrected for exception reporting are presented in Table 5.

Prevalence of chronic diseases and poor performance

Reporting bias may be introduced by differential prevalence rates for the chronic diseases which feature in the QOF. Because the poorly performing practices were located in more deprived areas, which could be expected to have higher disease prevalences, we adjusted for deprivation, ethnicity, age and gender. Prevalence rates for most of the chronic diseases were lower than expected in the poorly performing practices (Table 6).

Discussion

Main Findings

We have defined a cohort of 212 practices (3% of all practices in England) which remained in the bottom decile of QOF performance during each of the first four years since the introduction of the QOF. Smaller practices (fewer full time equivalent GPs) and practices with older GPs were more likely to be ‘poor performers’; the association was strongest for singlehanded GPs and practices in which the average age of GPs was over 65 years. In spite of improvements over the last four years, the mean QOF score of these poorly performing practices still lags 165 QOF points behind the remaining practices. Performance was unevenly diminished in the poorly performing cohort. Particular shortfalls were noted for indicators in the chronic disease categories of depression, psychotic illness, palliative care and epilepsy. Large shortfalls in individual targets were observed, particularly those relating to mental health issues or the demonstration of well kept clinical records containing clinical summaries, or ‘problem lists’.

Table 6 QOF chronic disease prevalence: recorded prevalence in poorly performing practices

QOF chronic disease category	% prevalence in poorly performing cohort (expected prevalence ^a)	% prevalence in remainder of practices	P value (significance of difference)
Asthma	4.83 (5.41)	5.71	<0.001
Blood pressure	11.70 (12.06)	12.93	<0.001
Cancer	0.79 (0.93)	1.06	<0.001
CHD	3.32 (3.28)	3.51	0.02
COPD	1.43 (1.46)	1.51	0.15
Diabetes	4.07 (4.11)	3.96	0.17
Epilepsy	0.57 (0.58)	0.59	0.05
Mental health	0.78 (0.84)	0.75	0.21
Stroke	1.24 (1.44)	1.60	<0.001
Hypothyroid	2.11 (2.34)	2.68	<0.001
Heart failure	0.65 (0.71)	0.75	<0.001
Palliative care	0.08 (0.11)	0.12	<0.001
Dementia	0.31 (0.36)	0.40	<0.001
CKD	1.70 (2.59)	2.88	<0.001
Atrial fibrillation	0.89 (1.08)	1.25	<0.001
Obesity	7.11 (7.75)	7.97	<0.001
Learning disability	0.22 (0.27)	0.27	0.004

^aExpected prevalence in poorly performing cohort of practices (2007/2008) after correcting for social deprivation, ethnicity, age and gender profile of practices

QOF = Quality and Outcomes Framework

Limitations

The main limitations of this study were the limitations of the QOF itself. Many criteria of excellence such as personal care and diagnostic skill are difficult to capture by any performance indicator, whereas some eminently measurable aspects of care quality are included in other performance measures but not in the QOF.² QOF performance is therefore only a snapshot of overall practice performance. Practices which appeared to be poorly performing in our study may have offered excellence in other domains of care which were not included in nationally reported data. In particular, there is evidence that singlehanded practices offer higher levels of access than group practices and offer a degree of continuity of care which few group practices can match.⁷ Only qualitative studies involving visits to practices and interviews with staff and patients are likely to determine whether performance was globally or selectively diminished in the poor performers identified in our study.

Implications

This is the first study to report on the characteristics of practices performing consistently less successfully in terms of QOF achievement. True, poorly performing practices accounted for only a small proportion of all practices (although less stringent definitions would have substantially enlarged the cohort), but these practices provided the primary care for just over 700,000 registered patients. Patients are loath to change their GP⁸ and there is no evidence that patients in poorly performing practices are more likely to register elsewhere. Breaking this deadlock will be difficult to achieve unless the process of informing patients and changing GPs is made easier for patients. Moreover, QOF performance did improve in the poorly performing practices over the four years of the study, but the remaining gap between these practices and national average scores in year four was substantial at 165 QOF points.

Previous regional studies have reported little or no difference in the clinical performance of singlehanded practices once the results were adjusted for confounding,^{9,10} but national studies have consistently demonstrated poorer achievement.⁵ One option for improving reported quality achievement is to develop loose associations (forming networks) between small practices, but whether these can bring about quality improvement is not established.¹¹

The 2004 NHS Contract for GPs in England removed the requirement for GPs to retire at 70 years.¹² Our results question the wisdom of allowing elderly GPs to continue in practice without additional checks on the quality of their care, although we cannot be certain that alternative explanations, such as poor recording of performance, did not contribute to low scores in these practices. Future developments in primary care such as compulsory revalidation and practice accreditation may ensure that only practices offering high quality care will retain their NHS contract. Both processes are likely to emphasize professional values that are assessed by peer review and practice visits, rather than the data driven emphasis of the QOF.¹³ Poor performance affected most aspects of QOF, but we have identified specific indicators which are particularly poorly delivered in the poor performance cohort, some of which may be remediable by specific interventions. More broadly, the shortfall in poorly performing practices was more organizational than clinical, suggesting that these practices may benefit from greater managerial input. Poorly performing practices also reported lower than expected prevalence

rates for common chronic diseases.

Under-reporting of chronic disease raises concerns about the use of QOF-derived prevalence rates for resource allocation purposes (which could selectively disadvantage more deprived areas) and also for the quality of care provided to patients whose chronic disease has not been recognized or coded onto a clinical 'problem list' by the GP.

Finally, having identified a cohort of relatively long term poorly performing practices, the challenge for researchers is to identify successful interventions for transforming these practices, even when poor performance appears to be entrenched.

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E. Do systems and complexity theories aid our understanding of poor performing general practices?

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Abstract

The scope of this paper is to introduce systems and complexity theories as a potential framework for understanding poor performing general practices. Whilst systems theory emphasises the linear interaction and interrelationship of parts of an organisation, complexity theory concerns the study of those systems that feature non-linear dynamics. As complexity theory has its roots in systems theory, it is appropriate to explore the two theories together. The strengths and limitations of using each theory as a lens for viewing poor performance in general practice are explored.

Background

Before discussing the finer points of systems and complexity theories, the concept of poor performance in general practice warrants an introduction. Performance in general practice tends to take on a government policy-driven definition, inextricably linked to notions of 'quality'. Overwhelmingly, quality is presented using policy rhetoric as something measurable that can be achieved through meeting pre-defined top-down targets. The drive for improving quality in health services through performance indicators is seen as a key feature of the Thatcherite New Public Management introduction of market incentives to improve the efficiency of public services (Walsh, 1995). New Public Management was embraced by New Labour's White Paper "Saving Lives: Our Healthier Nation" (Department of Health, 1999) with the establishment of targets in priority areas to reduce health inequalities.

Following on from this policy trend, in 2004 the Quality and Outcomes Framework (QOF) was conceived as part of the new General Medical Services Contract (nGMS) (Department of Health, 2003) and became the dominant model for monitoring the quality of general practice in England on a 'pay-for performance' basis, accounting for around a third of a practice's income. General practices receive payments for QOF points' achievement on a variety of indicators in clinical, organisational and patient experience domains – currently with a 1000 QOF points maximum.

Against the policy backdrop of improving the quality of patient care through measurable targets becoming a key preoccupation within health services (Elwyn & Hocking, 2000), QOF has become synonymous with general practice performance in the language of health management and policy-makers. Indeed, there runs the risk of an overgeneralisation by labelling general practices on the basis of persistently lower than average QOF scores only as 'poor performing' (Peckham & Wallace, 2011), and not least publicly with QOF data not dissimilar to league tables available in the public domain.

There is recent evidence that 141 general practices have continued to underperform on the QOF, remaining in the lowest 10% of QOF scorers nationally since the framework's inception

(Ashworth et al., 2010). The strongest predictors of QOF underperformance appear to be practices which are small and single-handed. Westland and others (1996) argue that poorly defined management structures are a feature of single-handed practices and impact negatively on performance. De Koning et al. (2005), looking at stroke prevention, discovered that on the other hand, general practitioners with a higher level of integrated organisational structures (e.g. effective record keeping) were less likely to deliver suboptimal care. However, single-handed practices, whilst not having the infrastructure to report their QOF-related activities, may offer a more personalised service and better accessibility to a named GP for patients (Van den Hombergh et al., 2005).

It can be seen therefore that factors assumed to impact on the quality of a practice can be placed within the context of the practice as an organisation. Definitions of what constitutes an organisation vary depending on one's theoretical perspective (Handy, 1999). A general definition may be simply 'a group of people who work together'. The link between how a practice functions organisationally and the quality of the service it delivers has been made within published literature. For instance, Huntington and Gillam (2000) discuss the challenges some organisational features of general practices pose to nationwide quality improvement programmes, such as lack of technical skills and effective leadership.

Organisational characteristics of a general practice can also have an impact on adherence to clinical guidelines (Wiener-Ogilvie, S., 2008). Therefore, for the purpose of this paper, poor performing general practices will be viewed as synonymous with their organisational context. Indeed, the central concerns of both systems and complexity theories are to understand the way in which organisations function. Both theories will be now be explored in turn.

Introducing Systems and Complexity Theories

What is systems theory?

Attempts at defining systems theory have been made by numerous commentators. Systems theory is most often associated with the work of the biologist Ludwig von Bertalanffy. Bertalanffy emphasized the existence of principles common to all systems in all scientific fields. He argued that all systems are the product of the connectedness and relationships of their components (Von Bertalanffy, 1968). Furthermore, Bertalanffy's theory called for a shift in focus from these components to the whole. In this vein, Sweeney (2006) describes one key characteristic of systems thinking as presenting systems as properties of the whole, none of these properties being held by the individual parts themselves. It follows that the properties of the system are destroyed by reducing the system to its component parts. Here parallels can be drawn with Gestalt Psychology. A system is not just any set of components, rather its essential property is that as a whole it is greater than and different from the sum of its parts (Köhler, 1929).

This approach can be set up in opposition to reductionism. Jackson (2003) explained reductionism in the context of systems as a 'traditional scientific method (which) sees the parts (of a system) as paramount and seeks to identify the parts, understand the parts and work up from an understanding of the parts to an understanding of the whole'. The key limitation of the reductionist approach is that by looking at the components of a system in isolation, the

interactions and relationships between them may be missed. Jackson instead proposes that by viewing a system as more than the sum of its parts, one builds up a rich holistic understanding of that system. Indeed Poincare (1958) described the aim of science itself as ‘not things in themselves, but the relation between things. Outside these relations there is no reality knowable’

Yet to move beyond the realms of pure theorising, systems theory can also hold practical applications for understanding organisations. Keep (2005) described systems theory as ‘a powerful analytical construct in the study of organisations, that suggests the concept of an organisation having interrelated parts’. Systems theory can therefore be viewed as a construct for organisational analysis, one that focuses on the organisation as a system consisting of components which interact to form the organisation in its totality.

Systems theory as applied to organisational study can be classified into three key perspectives – rational, natural or open system (Scott, 1992). The rational systems perspective sees organisations as formal structures consisting of clear cut rules and roles, defined so in order to meet the organisation’s objectives. The emphasis here is on properly applied control resulting in attaining an organisation’s goals. Checkland’s (1994) definition of hard systems thinking is relevant to this perspective, whereby the world is assumed to consist of a set of parts which can be systematically engineered to achieve objectives. However, there also exists a soft tradition within systems thinking, which views the world as problematic, particularly in terms of human relationships binding the parts of a system, and has an interest in the process of inquiry into these problematic situations that make up the world.

Along these lines, the view of the organisation as a natural system places more emphasis on informal structures and goal complexity. The interest in the systems theory approach is in how players within an organisation act within the context of its rules and formal structures. The organisation is not seen as holding a unitary goal, rather a plurality of aims and interests, which at times can be conflicting. From the natural system standpoint, the organisation does not exhibit highly formalised social structures, but they are self-evolving adapting systems.

Lastly, the open systems perspective emphasises on the other hand process over structure. Organisations are not closed systems but they are influenced by their external environment. This can be understood through von Bertalanffy’s original biological analogy when illustrating his systems theory; the dynamic interaction of the internal and external environments is likened to the selective exchange of a semi-permeable cell membrane. Therefore an organisation’s ability to meet its goals is ‘dependent on continuing exchanges with and constituted by the environments in which they operate’ (Scott, 1992).

It could be argued that these three perspectives simply reflect different views about how an organisation attempts to meet its goals. There is a sense of a move away from a linear approach to studying organisations as systems to a non-linear paradigm. Within such an approach, components of a system not only relate to one another, but also adapt and evolve, at times in unpredictable ways complicating the process by which the goals of an organisation are attempted to be met. Clearly the key characteristic of an organisation in systems theory is that its constituent parts relate to one another in order to meet a shared goal or a set of goals. Indeed Deming (1989) boldly stated that ‘without an aim, there is no system’. There is no doubt

therefore that a study of general practices as organisations must take into account the ways they work in order to meet their goals. And indeed to go a logical step back, what those goals actually are, for instance whether or not QOF performance features highly in the priorities of the practice. This leads onto the question of to what extent systems theory has been applied to the study of healthcare organisations, and in particular of general practice. This will be explored in the following section.

Systems theory & health services research Systems thinking has obvious relevance to understanding healthcare organisations. In line with systems thinking healthcare can be described as ‘as a set of connected or interdependent parts or agents—including caregivers and patients—bound by a common purpose and acting on their knowledge.’ (Institute of Medicine, 2001). Indeed systems theory has an established reputation of applicability to health services research. Anaf and others (2007) proposed combining systems thinking with case study research in order to study health services in an interpretivist exploratory framework. The case of the health service therefore becomes a specific, unique, bounded system with working parts (Stake, 2003). Anaf and colleagues argue that this combined approach can yield considerable insights, particularly in studying health services quality. Thus the systems case study approach has particular relevance to this study, as it allows for gathering multiple perspectives of players within a GP practice and as Anaf and others suggest, paints a picture of the impact of both the general practice case and system on quality.

Systems theory has been used in research, but also as a theoretical framework for understanding healthcare services and as a management tool in health. Hogg and others (2008) argue that primary care organisation is best viewed through the theoretical lens of systems theory. They support the aforementioned open system perspective and propose an analysis of the sociopsychological, organisational structure and ecological factors. Therefore the behaviours of individuals, the organisation’s structural features and the influence of the external environment are of key interest to enriching the understanding of primary care organisations, such as the general practice. Hogg and others also suggested that this approach had an important role to play in the study of systemic drivers towards (and presumably away from) quality in primary care. No doubt, this is of particular relevance to understanding poor performing general practices.

Keep (2005) listed some specific uses of systems theory in organisational research. These are - diagnosing individual and group behaviour, examining power relations, diagnosing environmental relations and establishing systems for learning in organisations. These uses can be directly applied to a general practice setting, both as a research method and a management tool. An enquiry of poor performing GP practices could explore how the senior partner relates to his reception team for instance and in turn how power is distributed within that interaction. The Primary Care Trust or Clinical Commissioning Group could both be viewed as the external environment and the extent to which their top -down mandates infiltrate the practice semi-permeable boundary could be analysed.

In the spirit of setting a solution-focus from the outset, one could develop an evidence-base for the types of systems which would be appropriate to improve the participants’ QOF scores. Research of this nature was conducted by Geboers and others (2002) with 39 general practices in the Netherlands. They used indicators to measure practice organisation, data management,

quality improvement, patient satisfaction, and medical performance. Those data were then used to drive quality improvement initiatives within the practices studied, based on systems which facilitated performance within the identified domains.

In fact, Rhydderch and others (2004), in a review of general practice research from a number of countries, argued that systems theory is the dominant managerial approach used to drive indicator-based quality improvement programmes. Although these authors saw the benefits of systems thinking in fixing the current way of doing things, they proposed that this approach created too much homogeneity. This may in part be due to the systems approach presenting the general practice organisation as a neat system which can clearly be manipulated with quality improvement initiatives in order to bring about change. Rhydderch and others instead support striking a balance between systems thinking and an approach which anticipates and makes sense of likely changes. They view the role of approaches which take account of the complexity of general practice as playing a key part in striking this balance. In fact there has to an extent been a move away from systems theory towards understanding healthcare services, in particular primary care, as complex systems (Miller et al., 1998). Before the use of complexity theory in health services research is explored however, the next section of this chapter will present the key features of this theory.

What is complexity theory?

Complexity theory is the study of systems that feature non-linear dynamics. Systems are adaptive, consisting of local agents whose interactions lead to continually emerging new behaviour. Change emerges as a result of interactions between players at a local level in the complex system and between the system and its external environment. Complexity can be defined as the ability of a system 'to switch between different modes of behaviour as the environmental conditions are varied' (Nicolis & Prigogine, 1989). In other words, complex systems are able to adapt to their environments. Within this tradition systems are seen as having the ability to form new behaviours and characteristics in order to reach their goals. Frenk (1993) claimed that whatever the goals of the organisation, as an adaptive system it will invariably move towards increasing complexity as it tries to reach those goals. Therefore complexity theory is clearly rooted in systems theory, observing the goal-oriented relationships between parts of the system, however with a move away from cause and effect modelling.

The term complexity itself refers to the middle state between an ordered and linear behaviour and a chaotic one. The nature of complexity is that it is the product of a 'myriad of facets' (Dodder & Dare, 2000). It can be argued that one of the strengths of this multi-faceted approach is that it challenges certain assumptions about how an organisational system functions. A recent report into the use of complexity theory in health services research by the Health Foundation (2010) claims that the following hypotheses are contested by complexity thinking: that every observed effect has an observable cause, that even the most complicated things can be understood by breaking down the whole into pieces and analysing it and that if past events are sufficiently analysed, this will help to predict future events. This no doubt paints a picture of human systems, of which the health service is one, as an unpredictable complicated mass.

On the other hand Sweeney (2006) described complexity as an uncertain dynamic state that conversely produces self-organising behaviour. There is therefore a tendency within complex systems for coherent behaviour to emerge from what seem to at first be random interactions. Another paradox was highlighted by Jantsch (1980) who pointed out that the more freedom there is in self-organisation, the more order there is. One could postulate from this that topdown quality improvement initiatives, such as the QOF, remove some of the freedom of selforganisation in general practice. Perhaps when the goal of the practice is not achieving high QOF scores, the potential for self-organisation around other goals is limited and chaos, rather than order, ensues. The self-organising behaviour is caused by a positive feedback loop within the organisational, or in fact any, system. Those actions that result in positive outcomes will be given preference over others, establishing repeating patterns of behaviour, which manifest as stable characteristics of the system.

Lastly, complexity theory can be viewed as an evolutionary systems theory whereby organisations do not achieve success because of their ability to predict and create planned strategies. They achieve success because of their ability to constantly realign with the environment (Burnes 1996). A key feature of healthcare organisations is the need to adapt to a wide range of external influences and stakeholders, be it the constant assault of new policy mandates, or the changing health needs of the populations they serve. In this vein, Janecka (2009) described healthcare services as ‘arranged in ever-expanding circles of influence’, communicating the extent to which the health service is a self-evolving and unpredictable entity. The next section will explore complexity theory applications in the field of healthcare, with some examples taken from general practice.

Complexity theory & health services research

Plsek (2000) is considered to be one of the key commentators on complexity theory as applied to healthcare organisations. Through his appraisal of the US healthcare system, he promoted complexity as a new paradigm to guide an understanding of how systems work in healthcare. Plsek identified certain features of healthcare which result in system complexity. These include the need for care to be based on continuous healing relationships and customised according to patient needs and values. Additionally the priority given to cooperation and collaboration amongst professionals, as opposed to preference being given to professionals’ fixed role over the system, results in non-linearity as a feature of healthcare services.

Fraser and others (2003) reframed this in the context of UK healthcare. Although they coined systems in health as ‘agile’, these to a large extent mirror the qualities of complex adaptive systems. These complex characteristics of healthcare services include flexibility in roles within a team and rapid changeover (e.g. in operating theatres). These principles of agility have for example been used to redesign older people’s services in London. It appears therefore that complexity theory can not only be used as an explanatory framework but as a tool for improving healthcare services. Rhydderch and colleagues (2004) support an approach which precedes efforts to change general practice by efforts to understand it through complexity theory. The focus is on analysing processes and structures in a way that helps a team to have a sense as to what works well and what could be improved.

Such a change may be brought about by focusing on the features of an organisation which

pertain to specific complexity principles (Mitelton-Kelly, 2003). These are complex responsive processes (observing outcomes/'ripples' of conversations, actions, decisions), relational dynamics (interactive dimensions including the interpersonal, social, technical, economic and global), adaptations and co-evolution (connectedness within and between systems and their environment) and self-organisation (emergent properties of the healthcare organisation which cannot be predicted in advance). A similar model has been used in primary care itself, as a methodological framework for analysing GP decision-making processes and how an evidence base is constructed by the GP (Mears & Sweeney, 2000). The suggestion here being that decisions are made a non-linear fashion and therefore complexity theory is an appropriate tool for an enquiry of this kind. In this vein, Hassey (2002) argued that complexity theory is a useful framework for understanding consultation in general practice, given that the dynamics between a patient and general practitioner seldom follow linear principles.

Like general systems theory, complexity theory has also been used as a management tool to bring about change in the healthcare delivery both at the policy (Frenk, 1993) and organisational level (Litaker et al., 2006). Litaker and colleagues postulate that while complexity in healthcare is sometimes viewed as problematic, its presence may also be highly informative in uncovering ways to enhance health care delivery. This is particularly the case when complexity represents unique adaptations to the values and needs of people within a general practice and interactions with the local community and health care system. This implies that quality interventions in general practice should be implemented with a flexibility that acknowledges the uniqueness of and variation within primary care practices. The key is to develop a local quality improvement strategy that is acceptable to and works within the context of the specific general practice system.

However, one of the limitations to Litaker and others' study may be that the local context of a general practice in all its complexity can conversely be rather difficult to measure in order to create a tailored quality improvement initiative. The next section of this chapter will explore the limitations of systems and complexity theories in greater depth.

Discussion

Limitations of systems & complexity theories as theoretical frameworks

Systems and complexity theories may well have their limitations as theoretical frameworks. Trochim and others (2006) identify the key limitation of applying a systems approach is the breadth of systems science and how overwhelming the vastness of the literature and the jargon within it can be to the healthcare services researcher. On the other hand the wealth of literature on this subject can equally be viewed in the positive light of a huge resource to draw on in the development of a theoretical framework for understanding poor performing general practices.

The poor performing general practice, studied in the context of systems and complexity theories would be viewed as an organisational system of components interacting to achieve the goals of that practice. Although at times formalised through rules and organisational structures, these interactions are largely complex, non-linear and adaptive. Through positive feedback stable patterns of organisational behaviour are established.

Boyett and Boyett (1998) argued that one of the key frustrations with systems theory is that there are no right answers about a given system, rather simply a range of actions is studied, alongside the variety of consequences they produce for the system. This implies that systems theory can be rather general, rendering it difficult to operationalize and evaluate empirically. This may be a particular problem for designing quality improvement schemes such as the QOF on a non-linear model. This does not of course mean that systems theory does not have its place in an explorative non-empirical study – one with the aim of improving understanding of poor performing general practices. Yet despite systems theory providing a conceptualisation, it may have poor explanatory power because its constructs are difficult to identify clearly and measure.

However, one could argue that such is the nature of the NHS itself. Robinson and Le Grand (1994) in a King's Fund report into NHS reforms aptly wrote that 'there are rarely simple answers to simple questions, usually because the questions are not actually simple'. This has implications for one-size fits all quality improvement initiatives such as the QOF, which are perhaps based on the assumption that simple questions which can be reduced to a set of measurable indicators can indeed be asked.

Lastly, systems theory can be criticised for what is its subtle assumption that all parts of a system have equal power and make an equal contribution to the organisation as a whole. This suggests that in studying general practices it is important to analyse the distribution of power and relative influence of parts of the system on the whole organisation. To some extent the application of complexity thinking may overcome these limitations by viewing power as dispersed and decentralised within a system, with the overall behaviour of the system being the result of many decisions made constantly by individual agents (Holland, 1992).

Yet complexity theory is not without its own limitations as a theoretical framework. One such limitation was highlighted by Levy (2000) who was writing about the practical implications of using complexity theory to further the understanding of how to improve organisational processes in general. He claimed that complexity theory, whilst furthering the understanding of organisational processes, is difficult to utilise in practice to bring about change. Yet there is some evidence that beyond the theoretical, the theory has been used to drive change in healthcare, for instance through enabling doctors to make adaptive strategic decisions (Ashmos et al., 2000) and to plan quality improvement initiatives in general practice (Litaker et al et al., 2006).

Complexity theory has also been criticised for its lack of real time applicability. As it seeks to challenge the chain of cause and effect within linearity, the outcome which may emerge from the input may only be recognised post the event, in retrospect. Frenk (1993) claimed that it is crucial to develop a health system that not only has the adaptive ability to react to crises, but also has the skills to anticipate problems before they happen. Therefore the unpredictability inherent to understanding organisations though the lens of complexity theory, may render it limited in its application to understanding a range of phenomena, as well as to improving healthcare delivery.

Furthermore, it has been claimed that 'complexity' may be an excuse for not striving to clearly understand the dynamics of a healthcare organisation (The Health Foundation, 2010). To an extent this supports the need for a theoretical framework to be a combination of linear and non-

linear approaches. This suggests that organisational modelling, often quite static in nature, has the potential to offer a rich picture of poor performing general practices when combined with complexity theory. Furthermore, the players within an organisation may employ goal reaching strategies which are neither rational (linear) nor emergent (non-linear). Sweeney (2006) uses the example of gaming A&E waiting times targets to illustrate this point. It is clear that A&E departments encouraging ambulances to form queues outside and not letting patients disembark the ambulances until they were able to be seen is neither the product of rational thinking nor of feedback dependent emergence.

There is a risk that through applying complexity theory as a general framework, the organisational processes of poor performing general practice may be abstracted out of its lived day-to-day reality, particularly at the individual level. Yet, perhaps this is simply the limitation of theoretical frameworks by their very definition. In defence of complexity and systems theories, research cited previously in this chapter has demonstrated their applicability in driving organisational change 'at the coalface'. Furthermore, complexity theory allows for greater flexibility, not constrained by the rigidity of mapping how systems interconnect. Given the richness of general practice, complexity theory may well form a stronger theoretical framework for understanding its underperformance.

Concluding Remarks

To sum up it appears that the shortcomings of both systems and complexity theories centre on the difficulty of adequately measuring the phenomena of interest. There is a sense in the literature that complexity theory in order to survive as a useful theoretical framework must 'move beyond the festival of bad metaphors' (Axelrod & Cohen, 2001). Yet this perhaps begs the question of whether complexity can ever truly be measured in quantitative terms and that numerical quality improvement frameworks such as the QOF have only limited value in aiding the understanding of performance in general practice. Moreover, the underlying essence of good general practice may well lie in factors such as rapport, compassion and inter-personal skills to name a few (Ashworth & Kordowicz, 2010). As such targets are unlikely to capture all facets of performance, particularly in light of these qualitative meanings of quality of patient care in general practice.

The drive to measure may paradoxically hark back to the reductionism that systems and complexity thinking attempts to challenge. Undoubtedly, the application of systems and complexity theories as theoretical frameworks for understanding poor performing GP practices would produce a study which moves beyond the observed components of a practice organisation to the holistic products of the interrelationships of those constituent parts. In this vein, Green (2010) argued that it is necessary to recognise that measures based on complexity science deliver answers that differ from those of linear models in meaningful ways. Yet, most importantly, the aim studying poor performing general practices is not so much to measure complexity, but rather to present a picture of it grounded in particular organisational cases.

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F. Capturing general practice quality - a new paradigm?

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Whilst overwhelmingly quality is presented by policy-makers as measurable and as meeting pre-defined top-down targets, we argue that quality in general practice is multi-form and multi-faceted. Quality is a notion that is hugely difficult to pin-down in all its richness and complexity and countless attempts have been made at defining quality in healthcare. Definitions range from the more concrete - quality as access and effectiveness for instance (1), to the abstract – quality as purely a social construct rather than an objective entity (2). There therefore exists a clear challenge of unifying the practical realities of general practice with subjective norms into one concept.

The coalition Government's agenda preaches values of openness and transparency through improved information capture to raise the quality of patient care (3). The type of information favoured for this purpose tends to take a numerical form, usually lending itself more quickly and readily to comparisons across services and strategic decision-making than its 'softer' qualitative counterparts. The dominant method of data facilitation in general practice is of course the Quality and Outcomes Framework

(QOF), with us since the introduction of the nGMS contract in 2004. There is no doubt that measurement plays a key part in enabling focussed quality improvement initiatives, for instance by identifying need in specific patient populations, and on a wider-level is likely to be a valuable tool in supporting commissioning decisions. QOF monitoring has also resulted in the creation of the largest general practice database in the world, prompting research around processes and outputs and their relationship to outcomes in general practice.

However, increasingly monitoring is viewed as instrumental to quantifying quality. In the face of austerity, top down monitoring feeds into wider aims of justifying spending, delivering tax-payer value, and continued growth in productivity. It could be argued that all of these policy aims have become ingrained as NHS values no less, introduced into the public sector by Thatcher with the advent of market incentives to improve the efficiency of public services (4). We are all too aware that the policy rhetoric of raising general practice quality through data submission has been wholly embraced by successive governments. Yet, it is likely that instinctively this view feels rather short-sighted to those ‘at the coalface’ of general practice. Bold policy aims such as the implementation of ‘a more comprehensive, transparent and sustainable structure of payment for performance’ where ‘funding should follow the registered patient, on a weighted capitation model, adjusted for quality’ (3) appear to ignore the complexity of quality in general practice.

Increased monitoring poses a further paradox for quality capture. The resulting bureaucracy and a feeling of being ‘watched’ can lead to GPs’ sense of professionalism being undermined. It is not a new point of view that potentially reducing patient care to a ‘pay for reporting’ approach (5) can be demotivating and even reduce quality in non-incentivised areas. There is a further risk that data capture through monitoring is no longer simply a tool for improving the measurable, but becomes an end in itself, superseding its original purpose. This view is likely to resonate with the thousands of GPs across the country as they chase elusive QOF points come the end of the financial year.

Nevertheless, Lord Darzi (6) claimed that ‘we can only be sure to improve what we can actually measure’ and here we face the key paradox of quality measurement. Usable

definitions pertaining to process and output tend to reduce quality down to just that. In policy rhetoric, high general practice quality has become synonymous with high QOF scores. Yet, quality lies also beyond this in facets of general practice that can never be fully reduced down into measurable indicators – rapport, patient-centredness, kindness (that value described as the ‘most curative herb’ by Nietzsche) - those human dynamics of a consultation that make general practice the hub of the community that it serves. In fact, reflecting even on the four basic principles of medical ethics – autonomy, justice, beneficence, non-maleficence - suggests that what lies at the core of high quality care is greater than that which can be captured through measurable indicators. This is clearly one of the challenges for new CCGs. Whilst it is claimed that by placing the GP at the centre of local decision-making we can work towards true quality, it is simultaneously of great importance that a reductionist approach, despite easily lending itself to policy creation, does not overshadow the finer aspects of what it means to deliver quality in general practice.

Our own ethnographic research exploring the reality of practices labelled as ‘poor performing’ by the QOF (7), suggests that top-down target frameworks based on an arguably limited definition of what constitutes quality are only a partial lens through which to view general practice. However, in ways that QOF can never truly capture, these practices had intrinsic flaws with their organisational practices and knowledge of IT systems, problems with team work and burnt out GPs out of touch with recent professional guidance. They had evolved into chaotic organisations, unable to adapt to new practices, particularly in the face of a challenging deprived patient population. They were poor performing in both quantitative measures and in terms of the three core values described by Marshall, excellence as medical generalists, commitment to whole person care and patient advocacy (8). Yet, even more strikingly, we have met GPs whose low QOF scores are often the result of an outright rejection of the framework, and they proudly continue to be exemplars of the four principles of ethical medical care within their communities. It is not inconceivable that GPs who do not prioritise achieving high QOF scores are able to remain outstanding holistic practitioners, central to preserving what their patients perceive to be high quality care. The danger of continuously producing a reductionist picture of general practice quality is real. We need to be clear that this is because the two models of understanding quality, the

measurable on the one hand and the qualitative on the other, run in parallel rather than in conjunction with one another.

This raises the question of whether the time has come for a new enhanced model for understanding general practice quality. Undoubtedly, the focus on metrics has resulted in a demonstration of primary care exceeding expectations and able to deliver far more than anyone expected when the QOF was originally introduced. Metrics though distort the very activity that is being measured, producing contortions, sometimes extreme, as targets are at risk of becoming prioritised over patient care. It is not that targets are inherently misguided, nor inevitably de-professionalising, nor worse still, unethical. Rather, it is more the case that targets have become the sole arbitrator of quality with no countervailing model for articulating alternative definitions. We would argue that the qualitative needs to be put back into quality.

What is needed now is research that generates robust qualitative concepts of quality enabling the essence of excellence to be captured more clearly. The four principles of medical ethics may well be a useful starting point. Then for these concepts of quality to be tested on professionals, patients and health service managers alike until a consensus emerges of the key domains or components of quality. CCGs should develop a strategy for recognising and preserving the excellence within their practices which remains outside the breadth of current metrics. The College's "Good Medical Practice for General Practitioners" (9) was one of the first publications to define 'excellence' within primary care. The original concepts have remained relatively static since first published in 2008 and many could be developed into criteria which general practitioners might consider to be more closely aligned to shared professional values than current quantitative metrics.

In the model which we propose, quantitative indicators will have a central role both to define minimum acceptable standards but also to offer 'stretch targets' rewarding practices for exceptional achievements. However, these will be balanced by the development of qualitative quality indicators primarily focussing on excellence and more clearly capturing the narrative of a primary care which so often goes the extra mile, and beyond. It needs to be recognised however that to develop a qualitative insight, more time and resources are needed to capture general practice quality in all its

richness and complexity. Furthermore, quality is a self-evolving, fluid concept and as such indicators have to allow for continuous adaptation. It is a tall order, but undoubtedly one that gives due recognition to the true values at the core of high quality general practice.

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